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**Integrating Social and Clinical Services for
Improving Maternal Health Care:
Lessons from Mali and Ghana**

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Thesis submitted for the degree of PhD

2015

Department of Development Studies

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Declaration for SOAS PhD thesis

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Abstract

Although considerable progress has been made in the reduction of maternal mortality in Sub-Saharan Africa in recent years, mortality rates, especially in rural districts, remain critically high, while uptake of family planning and maternal health services is low. International approaches to maternal health have historically focused on low-cost, technical interventions which have failed to address the social barriers to health care experienced by women. International agencies are now calling for the integration of social initiatives with the provision of clinical services in order to address uptake issues and empower women with greater control over their health and bodies. Through an ethnographic examination of the health systems of the Kati district in Mali and the Shai-Osudoku district in Ghana, this thesis investigates the impact of integrating a social component into formal health service delivery on maternal health care. Taking an actor-oriented approach, I focus on the strategies and community networks generated by the health workers whose actions produce the health care relationships which are central to improving the uptake of services. I conclude by suggesting that the patterns generated by health worker strategies indicate the gaps inherent in the health systems in which they operate, and provide insight into how the integration of social and clinical components might be improved to benefit maternal outcomes.

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Abbreviations

ADF: African Development Fund

ASACO: Community Health Association

CARE: Cooperative for Assistance and Relief Everywhere

CEDAW: Convention on the Elimination of All Forms of Discrimination against Women

CHN: Community Health Nurse

CHO: Community Health Officer

CHPS: Community Health Planning and Services

CHV: Community Health Volunteer

CHW: Community Health Worker

CSCOM: Community Health Centre

CSREF: Health Reference Centre

CWC: Child Welfare Clinic

DFID: Department for International Development

DHS: Demographic and Health Survey

FGM: Female Genital Mutilation

FP: Family Planning

GAD: Gender And Development

GDP: Gross Domestic Product

GHS: Ghana Health Service GOBI: Growth, Oral rehydration, Breastfeeding, Immunisation

GoG: Government of Ghana

GoM: Government of Mali

HV: Home Visits

IMF: International Monetary Fund

INSTAT: National Institute for Statistics

MCH: Maternal and Child Health

MDG: Millennium Development Goal

MNLA: National Movement for the Liberation of Azawad

MOH: Ministry of Health NHIS: National Health Insurance Scheme

NGO: Nongovernmental Organization

ORS: Oral Rehydration Sachets

ORT: Oral Rehydration Therapy

PHC: Primary Health Care

PRODESS: Health Sector Development Program NDPC National Development Planning Commission

PSPHR: Health, Population and Rural Water Project

SBA: Skilled Birth Attendant

SPHC: Selective Primary Health Care

SSA: Sub-Saharan Africa

TB: Tuberculosis

TBA: Traditional Birth Attendant

UN: United Nations

UNDP: United Nations Development Programme

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

USAID: United States Agency for International Development

WHO: World Health Organization

Table of contents

Declaration for SOAS PhD thesis.....	2
Abstract.....	3
Acknowledgements	4
Abbreviations	5
Table of contents.....	8
Tables & figures.....	12
Chapter 1: Introduction.....	15
Research problem.....	15
Community health workers in Mali and Ghana.....	21
Analysing the integration of social initiatives: A dual context.....	25
A change in research strategy: the Mali coup	26
Thesis overview	28
Chapter 2: Policy approaches to health.....	30
The foundations of international health service models	31
Health policy shifts and the rise of primary health care	34
The rise of community health workers	37
The debt crisis, neo-liberalism and a second shift in health care approaches	40
The Washington consensus and health care: from human right to commodity.....	40
Selective primary health care	44
Health workers and seekers under SPHC.....	45
Maternal health care and women's right to health.....	48
From population control to reproductive rights	50
Feminist perspectives on maternal health	53

Integrating gender into community health care.....	55
Chapter 3: Constructing a theory from below: complexity for researching maternal health care	58
Theoretical basis	59
Actor-oriented approaches, ‘process’ and networks	62
The network as a tool of analysis	70
The emergence of the network as a theoretical form	72
Networks, gender and power.....	74
Potential problems of a networks approach	76
Building a theoretical approach to analysing maternal health care	78
Theoretical themes: formal and informal networks, strategies and ‘failure’	81
Analysing formal and informal networks	83
Strategies and limitations: brokerage and network failure	85
Chapter 4: Research methodology	89
Organising fieldwork in Mali	90
The Mali coup and its impact on the research design.....	91
Incorporating a comparative perspective: extending the analysis to Ghana.....	94
Data collection and analysis.....	96
Field adjustments.....	105
Locating myself in the research	107
Ethical issues	111
Photographs	113
Chapter 5: Overview of health provision in Mali and Ghana	114
Constructing Community Health Systems in Mali and Ghana	115
Selective primary health care.....	117

Focus on community health systems	120
Overview of development indicators and current health provision in Mali and Ghana	122
Mali health system profile	125
Maternal health care in Mali	129
District profile: Kati	131
Ghana health system profile	133
Maternal health care in Ghana	135
Community health planning and services	136
District profile: Shai-Osudoku	140
Gender and poverty: how uptake of community health services is shaped by inequality in Mali and Ghana	142
Mali	143
Ghana	145
Chapter 6: Mali ethnography	149
Informal networks: constructing community health worker relationships	150
Network ‘failures’ and limitations	169
Theoretical reflections	175
Informal networks for improving maternal health	176
Network failures	179
Integrating the social side of maternal health care	181
Chapter 7: Ghana ethnography	183
Implementing CHPS in Shai-Osudoku	184
Limitations of the CHPS blueprint	200
Health worker coping mechanisms: strategies and brokerage	208

Theoretical reflections: formalising networks	213
Integrating social and clinical components	214
Constructing community health workers	215
Chapter 8: Integrating Social Initiatives: Emerging lessons from two health systems.....	222
Key findings	222
Formal and informal networks	223
Strategies and brokerage	225
Impact of health worker strategies on maternal and reproductive health care provision.....	229
Integrating social and clinical components of medical provision for improving maternal health....	232
Integrating health and rights.....	236
Conclusion	238
Bibliography	242

Tables & figures

Fig 1:	Pregnant woman with young child, Ghana.....	16
Fig 2:	Participant Observation Undertaken in Mali in 2012	97
Fig 3:	Participant Observation Undertaken in Ghana in 2013	97
Fig 4:	Interviews and focus groups undertaken in Mali in 2012.....	98
Fig 5:	Interviews and focus groups undertaken in Ghana in 2013	99
Table 1.	Mali and Ghana: Selected population, human development, poverty and health characteristics	123
Fig 6:	Selling fruit in a market, Mali.....	124
Fig 7:	Mali Health Care System Structure.....	126
Fig 8:	Cooking area at a CSCOM, Mali.....	127
Fig 9:	A CHPS compound in Ghana.....	132
Fig 10:	Institutional Structure of the Ghanaian Public Health Service.....	134
Fig 11:	Skilled Birth Attendant (SBA) at birth (1998–2008).....	136
Fig 12:	A médecin chef's office in a CSCOM, Mali.	152
Fig 13:	Health care Networks in The District of Kati	153
Fig 14:	A clinic waiting area, Mali.....	154
Fig 15:	A poster urging pregnant women to ensure that they have transport to a facility if a caesarean section is required.....	158
Fig 16:	Waiting to be seen at a CSCOM.....	165
Fig 17:	Woman selling garlic, Mali.....	173
Fig 18:	Entrance to a CHPS compound, Ghana.	185
Fig 19:	Child welfare day at a clinic, Ghana.....	187
Fig 20:	The delivery room at a clinic compound, Ghana.	189
Fig 21:	A busy child welfare clinic, Ghana.....	195
Fig 22:	A CHO takes the opportunity to talk about family planning with a group of young people in a village.	197

Fig 23:	CHOs, Ghana	210
Fig 24:	CHO schedule	211

Community health workers must be of the people they serve. They must live with them, work with them, rejoice with them, suffer with them, grieve with them, and decide with them.

–Halfdan Mahler (Director-General of the WHO 1973-1988), 1986, cited in WHO 1989 p.6

Chapter 1: Introduction

Research problem

The 5th millennium development goal of improving maternal health sets a target of a reduction of the maternal mortality ratio by three quarters by 2015. Many developing regions are far from achieving this, and the reduction in maternal mortality has proven to be one of the hardest targets to reach. The maternal mortality ratio in developing regions is currently 14 times higher than in developed regions, with Sub-Saharan Africa having the highest maternal mortality ratio in the world at 510 deaths per 100,000 live births (WHO, 2014a). The 2014 report on the Millennium Development Goals warns that reduction in maternal mortality falls far short of its target, and calls for urgent action on maternal health to reduce preventable deaths.

Whilst much progress has been made in recent years, Mali and Ghana are two such countries that will substantially miss their targets for reducing maternal mortality. The maternal mortality rate in Ghana currently stands at 350 per 100,000 live births, and will not achieve its Millennium Development target to reduce this to 158 deaths per 100,000 births by 2015 (WHO, 2014b). In 2008, the Ministry of Health declared that the country's high maternal mortality rate should be treated as a national emergency, requiring significant attention and investment of resources directed at reducing maternal deaths. In Mali progress on improving maternal health has been slower than in Ghana, and at 540 per 100,000 live births, Mali has one of the highest maternal mortality rates in the world (UNICEF, 2014). The country will substantially miss its Millennium Development target of 300 per 100,000 live births (WHO, 2014c).

In both countries the distribution of health care facilities and personnel is vastly unequal, and the majority of maternal deaths are recorded in rural areas. In the predominantly rural districts of Kati (Mali) and Shai-Osudoku (Ghana) where fieldwork for this thesis was carried out, maternal mortality rates are substantially higher than in the nearby capital cities, and contraceptive uptake is extremely low. The health prospects of the poorest women living in rural areas are bleak; poverty and inequality are pervasive, and many are unable to access basic care during pregnancy or delivery.



Fig 1: Pregnant woman with young child, Ghana.

Photo by the author.

Although it is widely acknowledged that substantially improving maternal health in these countries will require sustained investment in technical interventions, this is only part of a more complex set of issues which need to be addressed. Poor maternal health outcomes, including high maternal mortality rates, are a product of a number of interconnected factors which together operate to make improving maternal health a uniquely challenging endeavour. Women's health care is characterised not just by a critical lack of resources, but by systemic inequalities which underpin women's experience of health and health care on a daily basis. National and international health policies have historically obscured the impact of poverty and inequality on women's health, focussing instead on low-cost, technical health care interventions. In Mali and

Ghana, overall poverty levels are significantly higher in rural areas, and the distribution and quality of health services reflect the urban bias of their respective governments in developing services since independence. In both countries, women also face numerous social barriers to accessing available health services, which reflect deeply entrenched patriarchal norms within communities and households.

The work of this thesis is not to provide a general explanation for the high levels of maternal mortality in Mali and Ghana, nor to interrogate the technical responses to poor maternal health which characterise public health approaches. My intention is rather to offer insight into one small part of the wider explanation for poor maternal health, by exploring the social contexts and relationships which underpin the delivery of maternal health services in these countries. The focus of this research is the health workers who are responsible for providing front-line maternal and reproductive health services at the community level, and their endeavours to grapple both with the limitations of the health systems in which they work, and the dynamics of power which operate in their communities. Through this analysis, I intend to demonstrate the ways in which health system deficits, deep inequalities within the community, and the particular demands of providing care in a complex and intimate area of people's lives contribute to poor maternal outcomes.

Historically, approaches to maternal and reproductive health have largely focused on low-cost, technical interventions alone, eschewing discussion of broader social and economic factors, and neglecting the potential of community health workers to address these issues. Post-independence, newly formed governments and international agencies were concerned with developing urban health centres and controlling the spread of disease, approaches which focused on populations as a whole rather than the welfare of individuals and the development of rural health systems. Significant technical advancements in immunisation made considerable headway in tackling child mortality, but did little to address alarming maternal health indicators which stalled without sustained investment in community health systems and skilled birth attendants. It was not until the Primary Health Care movement of the 1970s that the need to strengthen rural health services was addressed, and the role that could be played by community health workers was thoroughly investigated.

Community health workers were central to the expansion of primary health care services, ideally placed at a local level to tackle both ill-health and the causes of ill-health. Health workers with primary health care training could facilitate the rapid expansion of basic health services at low cost, whilst taking up health education and advocacy work in their communities. Permanent residence in the community presented the opportunity to build the relationships of trust with populations that were necessary to successfully advocate uptake of services and good health behaviour. Health workers could also act a bridge between communities and health services, advocating health service protocols, and representing community interests at the level of local health service management (Ofosu-Amaah, 1983). For many, community health workers had the potential to become catalysts for social change, extending their advocacy work to address the broader issues of social and economic inequality which undermined the health of their communities.

The value of health workers who offered both clinical treatment and addressed the social causes of ill health to furthering maternal and reproductive health was considerable. Not only was family planning and maternal health service coverage very poor, women also encountered numerous social barriers to the uptake of these services. The combination of income-producing, household and childcare duties left little opportunity to access services, and cultural beliefs related to family and pregnancy often prohibited uptake. In societies where women had few decision-making powers, community health workers could be powerful advocates for allowing them to access services, forming positive relationships with community leaders and educating both men and women about the value of maternal and reproductive health services.

Much as it was celebrated by many as a significant step forward in thinking about international health and development, the transformative aspect of community health workers' roles was often marginalised in favour of enhancing their capacity to provide basic treatment services. This trend was cemented with the advent of global economic crisis of the 1980s, which in many ways signalled a return to the low-cost, technical health interventions of the post-independence era. Primary health care became 'selective primary health care', which advocated the dissemination of technologies such as oral rehydration therapies and contraceptives, whilst neglecting the role of community health workers in addressing the social causes of poor health. The

introduction of user fees for health services during this period was devastating, particularly for women who faced a considerable economic burden associated with multiple pregnancies over their lifetimes, and often had little control over household expenditure.

The failure of selective primary health care policies to address high maternal mortality rates led to increasing pressure on international development agencies to invest in strengthening health systems, and to develop programmes which acknowledged the broader social and economic inequities which determined women's experience of maternal health. There is now a sustained interest in developing formally integrated community health systems, which recognises the benefits of mobilising health workers to combine social and community outreach components with the provision of clinical services. Yet there remain considerable disparities in the way in which non-clinical provisions are defined and implemented, while the role of community health workers in performing the integration of social and clinical components is not well understood.

There is a large body of literature which focuses on the need to employ health workers in such a way as to reach geographically remote communities and engage them with the health care system (WHO, 1990, 2006, 2008; Lush et al, 1997, 1999; Oliveira-Cruz et al, 2003; Macintyre, 2005) much of which continues to focus on the instrumental value of integrated services. Emphasis in policy literature in particular has been on the capacity of integrated health services to reduce costs, improve project management and to coordinate patient care (De Geyndt, 1995, Jamison et al, 2006). Much attention has also been paid to the capacity of health workers to perform health promotion roles in their communities, and the question of whether their activities should be explicitly linked to broader social development is central to debates surrounding the role of community health workers today (Bracht, 1999; Nyamwaya, 2003; WHO, 2006).

During the primary health care movement, health promotion work was viewed as a transformative endeavour, improving the quality of life of whole communities and providing opportunities for the enhancement of rights, political efficacy and social justice. However, the neo-liberal ideology of the past few decades has shifted the focus of health promotion from an approach which addressed power structures, to

one which focused more narrowly on behavioural change at an individual level (Woodall et al, 2012). This trend has been the subject of intense criticism on the part of women's health and rights advocates, who seek to harness the integration of social and clinical provision to facilitate opportunities to empower women with greater control over their health and bodies (Cook, 1999; Casterline and Sinding, 2000; Ashford, 2001; Freedman, 2005; Marmot et al, 2008).

Whilst there have been a number of discussions in different contexts about what the role of the community health worker should entail and their capacity to provide maternal and reproductive health services, there have been fewer attempts to investigate the provision of social and clinical services from the perspectives of the community health workers who perform these services on a day-to-day basis. This is particularly true of community health studies carried out in Mali and Ghana, of which few focus directly on community experiences of maternal health care, and even fewer on health worker behaviour in this health care context.¹

There is, however, a growing body of literature which suggests that the experiences, understandings, and strategies of front-line workers in numerous contexts have a profound effect on development outcomes, which can bring significant insight to bear on the capacity of health workers to influence maternal health outcomes in their communities. In her work on fieldworker discretion in implementing GAD policy, Goetz (1996) argues that staff at lower levels are 'de-facto policy makers', on the basis that their interpretations have a profound impact on the way in which projects are implemented. She notes that fieldworkers have the capacity both to undermine progressive project elements, and to promote positive change by finding new and independent ways to promote gender justice and redistribution of resources. Mosse and Lewis (2006) also draw attention to the social processes which define development policy implementation, including informal relationships the effects of which are unaccounted for by policy blueprints. This work is central to my research, which focuses on the impact of the relationships and strategies formed by health workers as they deliver maternal and reproductive health services in their communities.

¹ Perez et al (2009) produced a nuanced and informative study on community health workers in Mali, although their focus was their role in improving child health. It should also be noted that the health workers who were the principal subjects of this study were the community volunteers referred to here as *relais*, and not the staff of the government clinics upon whom my work is largely focused.

Several studies of health workers have underscored the importance of their role in integrating educative and transformative agendas with the provision of clinical services, highlighting their capacity to generate and maintain social relationships as they provide clinical services to their communities (Khan, 2008; Matlin and Gill, 2009; Mahmud and Sultan, 2010). The relevance of these findings to my own research context is supported by evidence from studies examining community health care in both Mali (Gage, 2007; Castle, 2011; Boidin et al, 2012) and Ghana (Nayonator, 2005; Phillips et al, 2006), which highlight problems with both delivery and uptake of services.

My research responds to emerging discussions on improving maternal health systems by demonstrating the power of health workers' experiences, understandings and strategies to influence maternal outcomes. Through my discussion of health workers' experiences navigating the community health systems of Mali and Ghana, I explore the mechanisms through which they integrate advocacy work with the provision of clinical services, and ask what the effect is of health system attempts to formally integrate this component with clinical service delivery. In focussing on this element of maternal health care provision, I hope to provide some insight into how the integration social and clinical services might be improved to benefit maternal outcomes.

Community health workers in Mali and Ghana

In both Mali and Ghana there are several different cadres of health worker operating at a community level, including nurses, midwives, birth attendants with basic training and community health volunteers. The health workers at the centre of my research live in the communities to which they are posted, and are in many cases the first port of call for women in need of health care and advice. They are often well acquainted with local women and families, and are involved in general community activities including social and religious events. In both countries, health workers use their position in their communities to promote positive maternal and reproductive health behaviour, and often employ innovative strategies to advocate uptake of services.

Health worker-community relationships in the district of Kati in which I conducted fieldwork in Mali, are largely informal. The majority of health workers on whom I

focus work at community clinics (CSCOMS) and are mandated to provide basic services including vaccinations, family planning, antenatal care and treatment of minor ailments. During my fieldwork I observed that, in addition to these duties, many health workers would advocate maternal and reproductive health services in their own time, talking to women and men in their communities and inviting women to their houses to receive advice. They would also use community health events such as vaccination days as opportunities to talk to women about family planning and antenatal care.

Whilst in Mali much of the advocacy work performed by community health workers was informal, the district of Shai-Osudoku in which I worked in Ghana was in the process of rolling out a community health programme in which specially trained health workers were required to visit households regularly with a view to monitoring health and advocating uptake of services. There the social component of health care is more formalised than in Mali, and community health officers (CHOs) would live and work in clinic compounds, performing advocacy work in their communities alongside basic clinical services. Ghana's community health system offers an interesting context with which to contrast the experiences of health workers in Mali, who must carve out opportunities for community engagement themselves.

In Mali, the clinics with which I conducted my research are all staffed by a head physician (*médecin-chef*), and at least one *matrone* (women health workers with about six months training who can perform uncomplicated deliveries). Some CSCOMS also had a permanent midwife (*sage-femme*) and a nurse. In addition to clinic staff, some of the villages in Kati had one or two community health volunteers (*relais*), who received five days training in basic health information regarding hygiene, and best health care behaviour for child and maternal health.

These health workers live and work in their communities, and many have developed their own strategies for advocating good maternal health practices and clinic services in ways that go beyond their government mandate. In addition to providing basic clinical services, some government health workers used their free time to talk with women and families in their communities about the benefits of family planning and maternal health services, whilst others invited women to receive advice and treatment free of charge in their own homes. Some *médecins-chefs* used their position in their

communities to connect with local authority figures in order to advocate maternal and reproductive health services. During their years of experience living in the same area, the majority of health workers had accrued a deep understanding of community beliefs and attitudes which allowed them to build productive health care networks and tailor their approaches to advocacy work.

Despite the innovative strategies employed by health workers to perform advocacy work in their communities, their efforts were severely limited by the constraints of the health systems in which they worked. Community health volunteers tasked with making health visits to community members had little training or support, and little time given that they had to maintain other jobs to support themselves. Clinic-based health workers were often unavailable in their communities due to their clinic duties, and were unable to travel to more remote villages due to lack of time and transport issues.

Health workers based in the town found it difficult to build the relationships of trust required to advocate maternal and reproductive health care outside of the clinic due to the fact that the population was diverse, growing rapidly, and unfamiliar to them. Health workers also encountered regular difficulties in their attempts to advocate clinic services to men, who in the majority of cases would make the ultimate decision as to whether their wives would use family planning methods or receive antenatal care at the clinic. Deeply entrenched cultural understandings of the position of women in society as subordinate to men continually undermined the efforts of health workers to promote clinic services.

I argue that the diverse and innovative strategies employed by health workers in Mali to further the uptake of maternal and reproductive health services in their communities demonstrates the critical role that community health workers can play in improving maternal health. Policy interventions must focus on increasing the capacity of health workers to use their positions in their communities to further advocacy work, in ways that permit them to determine priorities and use their own understandings to improve the health prospects of women. I suggest that examining the failures and limitations experienced by these health workers in their efforts to perform community and advocacy work is a key means via which deficits in the health systems in which they operate might be identified.

Observing the experiences and strategies of health workers in Ghana is equally instructive, this time providing insight into the benefits and limitations of a community health system which formalises the social components of community health care. Ghana's Community Health Planning and Services Programme (CHPS) is based on the principle that making community health workers available in rural areas and actively encouraging their integration with their communities will increase both community health knowledge and uptake of health services. During the initial implementation phase, health workers move to a newly designated CHPS Zone, and begin the work of treating patients whilst connecting with community members and authority figures. After this phase is complete, the idea is that a clinic compound is then constructed in consultation with the community, where community health workers and, ideally, a midwife will take up permanent residence.

Researching the activities of health workers in Ghana revealed patterns of uneven service delivery, and significant levels of deviance from the CHPS model which health workers were tasked with implementing. Some communities received more home visits than others, and some had never had a visit from a health worker since the area had become a designated CHPS zone. Only two of the four CHPS areas in which I worked had been able to retain a midwife, making skilled coverage extremely uneven. Health workers themselves struggled in many ways to juggle the demands of their communities, the CHPS blueprint, and their own wellbeing as they sought to carve out their lives as health care providers and community residents. I observed that in many cases deviance from the CHPS model could be understood as strategies employed by health workers to help them cope with and compensate for the realities of the health care contexts in which they worked.

I argue that in the process of formalising preventive and promotive aspects of community health care, the health service has created a 'blueprint' for building relationships within the communities which limits the capacity of health care workers to generate positive maternal and reproductive health care networks within the communities in which they are posted. As it stands, the CHPS programme illustrates the way in which the goal of bringing reproductive and maternal health services to 'the doorstep' (GHS, 2002:9) is affected by the politics of accountability, unclear and uneven implementation plans, and a model which disempowers health care workers

such that they struggle to generate strong networks for maternal health care in their communities.

I suggest that the integration of preventive and promotive aspects of community health care has been limited, and weakened by a poor understanding of how these aspects can be connected to positive maternal health care outcomes through the work of CHOs. Finally, I observe that just as the roles of CHOs are created and defined by the community health care programme, so they generate their own role definitions and brokerages between each other and their communities. These new relationships can be both beneficial and detrimental to the provision of maternal and reproductive health services, and must be understood as a product of the material conditions in which health workers operate.

Analysing the integration of social initiatives: A dual context

Studying the relationships, understandings and strategies of health workers in both Mali and Ghana facilitates an analysis of what happens to maternal health care relationships when they become a formal requirement of community health systems. What are the benefits to women's maternal and reproductive health of integrating a social component with the provision of clinical services, and what is lost or transformed through formalising this element? Through this analysis I offer insights into how the integration of the social and clinical components of maternal health care services functions in contexts where the provision of health services relies on complex elements that are not accounted for in policy blueprints.

In order to achieve this, I employ an actor-oriented approach which provides a view of the strategies employed by health workers to generate positive health care networks as they navigate the challenges of providing health care to women in their communities. Examining these strategies, I argue that the provision of maternal and reproductive health care produces distinct patterns which are generated by the actions and understandings of health workers. These patterns reveal much about the factors which affect the provision of maternal health care, and constitute a form which may be used to view the ways in which maternal health services construct and are constructed by those who provide them. I conclude by suggesting that the patterns

generated by health worker strategies indicate the gaps inherent in the health systems in which they operate, and provide insight into how the integration of social and clinical components might be improved to benefit maternal outcomes.

This thesis makes the following contributions to scholarship in the area of development, maternal health and health systems. Principally, I offer a contextual understanding of the integration of social and clinical approaches to maternal and reproductive health care in Mali and Ghana from the perspectives of health workers who perform this integration. I focus on their nuanced roles, relationships and understandings, examining the impact of their strategies on the integration of social and clinical services. This adds to existing work on integrated health systems, and responds to calls for research which furthers the understandings of the dynamics of the interactions of formal health systems with the communities which they serve, with a view to tackling barriers to implementation (Briggs et al, 2001; Ntsua et al, 2012.) Secondly, whilst research on health workers has tended to focus on the formal relationships which underpin health service delivery (Heaney and Israel, 2008), I examine this element alongside the informal relationships which are a fundamental part of maternal health, and argue that understanding both and the connections between them are central to enhancing maternal health care provision. Finally, my research makes a theoretical contribution to the study of maternal and reproductive health systems by drawing out the networking patterns of health workers and highlighting the potential of these patterns to indicate areas of deficit within these systems.

A change in research strategy: the Mali coup

Before I move on provide an outline of this thesis, it is necessary to alert the reader to a significant event which occurred during my fieldwork, which required considerable adjustments to be made to my research strategy and was deeply affecting on a personal as well as academic level. During my fieldwork trip in Mali on 22nd March 2012, a section of the Malian army launched a coup overthrowing president Amadou Toumani Touré and seizing control of the country. Within days, many political and military figures had been arrested or killed, and the president had gone into hiding. The leader of the rebellion Captain Sanogo made radio and television statements declaring military rule and announcing the leadership of the newly formed National

Committee for the Restoration of Democracy and State. A curfew was also announced, in addition to the closure of Malian airports and borders. In the days leading up to the putsch I had been working in a clinic in a town outside of the capital which hosted army barracks, and which became the site from which the rebellion was launched. When the news came that the presidential palace had fallen, I was thankfully in accommodation in the capital, which is where I was compelled to stay for the next few weeks, unable to leave due to widespread violence and civil unrest in the wake of the rebellion.

The events of the coup happened swiftly, and put an immediate end to my fieldwork in Mali. My original research project was designed to compare the strategies of government health workers with those of health workers employed by an international NGO, with fieldwork to have taken place solely in Mali. The events of March 2012 demanded a considerable rethink of the research design, as I had not been able to complete the portion of the research which focused on NGO providers. When I was eventually able to return to the UK, I set about redesigning the research such that I would be able to usefully compare the experiences of government health care providers in Mali with those of their counterparts in another country. This was a substantial endeavour and it was many months before I was able to arrange fieldwork in Ghana, a country which, having recently developed an integrated community health programme, offered a compelling site for comparison.

In many ways I feel that the inclusion of Ghana as an additional research context has enriched this study, and opened up the question of how community health workers provide social and clinical health services in contexts in which the integration of these components is a formal requirement of the health service. Adding the perspectives of community health workers in Ghana has provided me with a deeper understanding of the way in which health service constraints manifest themselves on a day-to-day basis, and of the nuanced ways in which health workers respond to these constraints. Yet while I am grateful to have had the opportunity to complete my research in Ghana, leaving Mali under the circumstances I have described was painful, and created as yet unanswered questions as to how the provision of maternal health services in the communities in which I had worked would be affected by political instability, the influx of displaced persons, and the withdrawal of international aid.

I return to the events of the coup and the project redesign in chapter 4 in which I outline my research methodology, but for now I turn to an overview of the thesis which follows.

Thesis overview

The first part of this thesis explores the policy, theoretical, country and health sector contexts of my subject, which inform my analysis of the ethnographic data which constitutes the second part of the thesis. Chapter 2 discusses the health care policies that have informed the provision of maternal and reproductive health care, and led to the call for community health systems to integrate social and clinical components through the deployment of community health workers. I outline the international context in which primary health care policy has been developed, and note the shift from rights-based approaches to technical-instrumental approaches. From there I discuss the impact of these policies on maternal and reproductive health, highlighting the crucial role to be played by community health workers in performing advocacy work which furthers women's health and rights.

My theoretical approach is outlined in chapter 3, which discusses the project of constructing an appropriate theoretical tool for understanding complex maternal health care relationships and the patterns that they generate. I take an actor-oriented approach, and critically assess the network as a theoretical tool through which the activities and understandings of health workers might be understood. Chapter 4 details the methodology, and discusses the selection of research contexts and the way in which fieldwork was organised in each country. I outline the methods used for collecting data, and their appropriateness for the subject and approach. Field adjustments are discussed, including the Mali coup which led to a shift in focus and the addition of a second research context. I also discuss the challenges I experienced locating myself in the research, and address ethical concerns, both those inherent in studying maternal health care contexts, and those which arose in the field.

Chapter 5 provides a detailed research context, with a view to explaining how the community health contexts in which health workers operate have developed, and function today. I discuss the way in which the health care trends described in the policy chapter affected the development of primary health services in Mali and

Ghana. Profiles of the current health systems in both countries are then provided, in addition to information about the districts in which I worked and the maternal health contexts of these countries. This chapter also discusses the deep inequalities inherent in both research contexts which underpin health workers' experiences of providing maternal and reproductive health care in their communities.

Chapter 6 is an ethnographic analysis of maternal and reproductive health care in the Kati district of Mali. It details the experiences of health workers and the informal strategies and networks they use to advocate maternal and reproductive health care services. Through this analysis, I demonstrate the capacity of health workers to generate innovative ways to improve maternal and reproductive health in their communities. A discussion of cases in which health workers are unable to generate the relationships necessary to advocate maternal and reproductive health services is also provided, and serves to illustrate the many constraints with which community health workers in Mali grapple on a daily basis.

Chapter 7 is an ethnographic analysis of maternal and reproductive health care in the Shai-Osudoku district of Ghana. Here the experiences of health workers are explored in the context of a community health programme designed to integrate social and clinical service delivery. The benefits of this integrated health system for women's health are discussed, before I move on to demonstrate the way in which health worker strategies reveal key deficits in the community health programme. The 8th and final chapter provides a summary of my key findings, and puts the findings from each context into perspective vis-à-vis one another. The impact of health worker strategies on maternal and reproductive health care emerges as a key artefact, in addition to the problems which arise when formalising the social component of community maternal health care. I conclude with a discussion of what the experiences of health workers in both contexts can tell us about how best to integrate social and clinical components in order to improve maternal outcomes.

Chapter 2: Policy approaches to health

The research presented here focuses on the experiences of health workers in Mali and Ghana as they provide maternal and reproductive health care services to their communities. In order to understand both the context of this provision and my decision to investigate maternal health services through examining the activities of community health workers, it is necessary to provide an account of changing approaches to health policy and the policy environment in which the events discussed through my ethnography took place. The shift in international health agendas from the disease control of post-independence, to policies informed by Health for All (WHO, 1979) to those driven by neo-liberal economic reform, is central to understanding the maternal health systems of Mali and Ghana in which my research was conducted, in addition to the changing conceptions of the role of the health workers who provide maternal health care to their communities.

Through this discussion I demonstrate how we have arrived at a market-led model of health care delivery which prioritises low-cost, technical interventions, and discuss the growing demand for integrated services which address the broader social and economic inequalities which undermine women's health and rights. This chapter is not intended to provide a comprehensive history of changing economic and health sector policies, but rather to highlight those trends which have influenced health sector approaches to maternal health and led me to focus on the community health workers who implement these policies.

This chapter is divided into five sections which together provide an account of health sector reform as it has shaped the provision of community and maternal health care. The first part examines the colonial and post-independence foundations of health sector approaches, and demonstrates the way in which these histories have shaped the provision of community health services today. Section two examines the policy shift to basic needs and primary health care approaches, which highlighted the role that could be played by community health workers. Part three acknowledges the role of the economic crises of the 1980s in reshaping the agenda for community health care, and discusses the detrimental impact of neoliberal health policies on health systems. Part four outlines the emergence 'selective' primary health care, and the way in which

the roles of health workers and their communities in developing services were narrowed to emphasise the instrumental value of their inputs. The final section highlights the impact of changing policy approaches on women's reproductive health care, and the ongoing attempts to integrate initiatives which address the broader social determinants of poor maternal health. This discussion emphasises the potential of community health workers to advocate women's health and rights in their communities.

The foundations of international health service models

In order to understand the health systems in which I worked in Mali and Ghana, it is helpful to review the events which foregrounded the creation of community health services. As Greene et al (2013) point out in their work on colonial medicine, colonial health structures are present to this day and examining the relationship between past and present health care ideologies through historical analysis is essential to understanding the current issues faced in global health care. Whilst an in-depth analysis of colonial health systems is beyond the scope of this chapter, it is necessary to acknowledge the colonial health system architecture upon which the health infrastructure observed in West Africa today was built. Africa's colonial history had left a distinct approach to social welfare, narrow and ideologically embedded in colonial administrations' desire to exploit the natural resources of their respective colonies. Desai (2014) notes that the centralised system of colonial rule was designed in such a way as to provide the basic infrastructure necessary for metropolitan life, catering only for colonial officials and the workers at the centre of developing industry.

The implications of this legacy for the administration of health care are considerable. The colonial welfare system was modelled on European infrastructure and almost exclusively centralised in metropolitan, colonial centres. According to Morales-Gómez:

Colonial social policy was restrictive both socially and spatially. In many cases across West and Central Africa, social services were located only in urban areas or neighbourhoods where colonizers were found in large numbers (1999:75).

The result of this approach was that the majority of people did not have access to health care, whilst the concentration of these services in centres of colonial power led to a dramatically uneven development skewed towards the elite who came to reside in well-provisioned towns. Colonial health systems reflected European approaches to health not only geographically, but also in their focus on developing curative medicine and epidemiological data collection, which became the task of medical centres in urban areas.

During this period, health workers were European professionals who had been trained in tropical medicine, and who were posted in colonies for the purposes of staffing hospitals in urban areas, and collecting epidemiologically significant information and general indicators such as mortality rates. Few medical facilities were available in rural areas, and the attitude of colonial medical institutions was that it was best to limit the disruption to rural African communities which may be caused by Western culture and lifestyle (Greene et al, 2013). However, the later colonial period saw the spread of missionaries whose approach towards rural health care was far more active. As sanitation and understandings of disease improved, the European population, including the expanding medical staff, brought their families to the continent. This development generated an expansion of missionary services, which, in contrast to the established colonial medical model which focused on populations, were primarily concerned with the physical and spiritual welfare of individuals in rural areas.

The notion that a diseased body indicates a diseased soul came to represent a powerful part of the history of colonial medicine, providing an alternative ideology which focused on individuals, rural communities, and the role of health workers in addressing not just clinical requirements, but also social and spiritual needs. Clinic and hospital visits were viewed as opportunities for conversion, and patients would receive spiritual counselling in addition to medical care (Vaughn, 1991). As medical missions grew, they became increasingly professionalised, and established the notion of expanding clinics and placing trained health care personnel into rural communities.

The work of medical missionaries popularised the idea of the “civilising mission”, and the important role to be played by health workers in this process. Yet, much as mission health centres expanded access to basic facilities, the majority of hospitals and

developments such as sanitation and transport links were bound to urban centres, whilst the spread of disease remained the primary concern of colonial administrations. Epidemiological investigations remained at the heart of colonial medical approaches, not least due to the prevalence of diseases such as yellow fever in Africa, and the spread of the cholera epidemic throughout Europe during the nineteenth century.

It was this urban-centred model which informed the transition from colonial to post-colonial states, supporting the new urban elites and promoting economic growth, leaving rural areas unable to benefit from these advantages. Many African historians have argued that it was beneficial for new post-colonial powers to maintain this urban-centred model as a base from which newly-formed governments could assert their authority (Wunsch and Olowu, 1995; Ake, 1996). Post-independence, African governments aligned themselves with international approaches to health and development, promulgated by organisations such as the Rockefeller Foundation which invested in the eradication and prevention of disease.

Disease-focused, vertical approaches to health interventions were powerful paradigms due to their efficacy and cost-effectiveness, and shaped international health policies for many years. Whilst many such interventions had great success, they were based on a narrow view of international health as a project concerned with populations rather than individuals. There was little consideration of the role that could be played by local populations or community health workers, or the social and economic factors which contribute to poor health. Indeed, evidence from Rockefeller Foundation records in the 1930s suggests that policy-makers actively avoided addressing diseases such as TB which were strongly linked to poverty and social factors on the basis that it was beyond the organisation's remit (Lowy and Zylberman, 2000).

Although the formation of the World Health Organisation in 1948 heralded a more inclusive discourse on health which promoted 'physical, mental and social well-being' in addition to disease control, they initially struggled to uphold this ambitious agenda. Their early successes were almost exclusively technological, specifically in the area of disease control through the widespread distribution of antibiotics and the development of vaccinations (Markel, 2014). The success of the WHO's smallpox eradication campaign in the 1960s was particularly influential in strengthening support for technological, disease-focused interventions.

However, despite the popularity of technological approaches, the WHO's mandate to promote social well-being represented an alternative narrative for those who wished to expand international health care to include social and rights-based approaches, and develop community health systems. As Brown et al (2006) point out, the tensions between technological, disease-focused policies and those designed to address the social challenges inherent in health sector reform have been present in the WHO, waxing and waning since its inception. Support for socially aware health sector reform began to build in the period after independence, fuelled by concerns over the limited scope of technological interventions. The transition to post-colonial states took place in a period of marked change in the international political climate, during which time socialist and civil rights organisations campaigned for approaches to development which promoted long term social and economic growth rather than short term technological interventions. Approaches to health care by international organisations also came under intense scrutiny, widely influenced by international political and economic contexts, in which the interests of multiple political powers shaped the construction and implementation of health policy.

Health policy shifts and the rise of primary health care

By 1970, the changing international political climate and mounting criticisms of the failure of technological fixes to generate lasting infrastructures or to consider local contexts and human rights led to a significant change in direction for international health policy. The colonial legacy and western health care development model had left huge disparities between health care provision in urban and rural areas, and this was highlighted in particular by the failure of the WHO's malaria eradication programme which promoted technologies without engaging the participation of local peoples, particularly in rural contexts. Even the eradication of smallpox campaign, which was phenomenally successful by comparison, revealed the limitations of technological programmes which did not engage with the peoples with whom they were working. Reports of forced vaccinations in India, Bangladesh and Ethiopia raised human rights concerns, in addition to leaving a legacy in which many communities did not trust public health campaigns. Further, the campaign had significant difficulties targeting smallpox in rural areas because cases often went unreported, especially in areas where no medical facilities were accessible to local communities.

This period was also characterised by a turbulent international political climate, in which conflicting political and economic interests were coming into play in the wake of decolonisation and the Second World War. US and Soviet Cold war superpowers had emerged, wielding significant influence over international economic and health care policies. US policymakers advocated market-led development strategies, whilst soviet powers fought to implement state-led programmes. In newly formed states, grassroots political and community organisations were emerging, drawing attention to the lack of health services in many parts of developing countries. In addition, many NGOs were already working with communities in Africa Asia and Latin America on health care and poverty alleviation, and became key conduits through which new approaches to health and development were implemented.

The concern over lack of essential health services chimed with the broader ‘basic needs approach’ popularised by the International Labour Organisation (ILO), which noted vast inequities in income distribution, and emphasised the importance of ensuring populations had access to the basic elements required in order to live well, including food, water and shelter, in addition to public services such as health care, sanitation and education. Unlike the technical, disease-focused approaches that had gone before, the basic needs approach focused on the lives of the poor, and invited strategies which enhanced the fulfilment of basic human rights (ILO, 1976).

The new focus on human rights and development of basic services, combined with criticisms in the wake of ‘vertical’ programmes such as the Malaria eradication campaign, led the then WHO president Marcolino Candau to call for a more ‘horizontal approach’, which expanded community health systems with the participation of local peoples. This new health care ideology became known as the Primary Health Care approach, and focused on developing rural health system infrastructure, incorporating preventative services, integrating local practices and inviting grassroots participation in the development of health services and rural providers.

The primary health care movement was boosted further by the appointment of Halfdan Mahler as director-general of the WHO in 1973. A long term campaigner for social justice and accessible health care, Mahler came into the role with a vision of primary health care which focused on comprehensive community provision informed

by a belief in the universal right to health. His community-based approach also represented middle ground between Soviet state-led health service strategies, and US market-led models (Basilico et al, 2013). The goal he set at the time was ‘health for all by the year 2000’, a phrase which became the slogan of the primary health care movement. Keen to generate community based-initiatives with which to strengthen health system infrastructure, he commissioned a study examining the ways in which the development of basic health services might be promoted on a global scale, research which fundamentally changed the WHO’s approach to the architecture and ideology of developing health systems.

It was argued that major national schemes were required in the area of community health care in order for health services to develop efficiently and effectively, and a set of principles were outlined to the WHO which shaped the ideology of primary health care moving forward. The recommendations received by the WHO were based on the principle that health systems should be designed based on the “life patterns of the population” and that the local population should be involved in the design and implementation of services (Litsios, 2007). The report also stipulated that preventative, curative and promotive services for communities and individuals should be integrated, and rely as far as possible on available community resources.

The new ideological approach to health care was enshrined in the ‘Health for All’ declaration of the 1978 international conference on Primary Health care in which Mahler’s goal of offering primary health care to all by the year 2000 was formally implemented. The Alma Ata Declaration emerging from the 1978 conference expressed a commitment to public health as a human right:

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. (WHO, 1978)

In addition to shifting international health discourse to a framework which viewed health as a human right and as inexorably linked to broader social and economic

development, the conference also brought the concept of the community health worker to the forefront of discussions of international health care.

The rise of community health workers

It was here that conversations about the potential of community health workers to expand services and facilitate broader social development began in earnest, influenced in part by the phenomenal success of Chinese ‘barefoot doctors’ who were making remarkable progress in community health in rural China. These state-appointed medics lived and worked in the communities they served, and focused on prevention through education in addition to providing basic medical services. Reports of the profound changes they were effecting in their communities were brought to the attention of international health policy makers after a number of physicians and academics made visits to rural Chinese communities and confirmed claims that epidemic diseases and infant mortality had been dramatically reduced after the introduction of community physicians (cf. Lee, 1974). The success of the emerging Chinese community health care system had highlighted the need for the WHO to adopt an approach which encouraged the training and placement of community-based health workers.

Guidelines emerging from the Alma Ata conference stated that the role of health workers should be developed from a community perspective, and that interventions should be carried out by health workers “most simply trained for this activity”. This marked a fundamental change in approaches to health care and health care providers, in which the needs of communities became the starting point for health system design. It was accepted that, rather than ‘expert providers’, health workers were required who could be given basic training at far less cost than that incurred by educating highly-skilled physicians, and who would be able to better understand the needs of their communities.

Community health workers came to be viewed as a principle means to address some of the key problems in improving primary health services, and were referred to by the WHO as “pillars of health for all”. According a WHO review of CHWs in 1983:

...the CHW has the potential to resolve at least three major impediments to the development of effective primary health care programmes:

- access of the entire population to the basic elements of promotive, preventive and treatment services;
- the cost of covering an entire population with services by the usual professional and paraprofessional personnel of the health system, which is almost always prohibitive;
- social relationships between health workers and the population, which are often a barrier, but which must be close and trustworthy if the population is to be effectively guided and influenced in health-related and development-related behaviour. (Ofosu-Amaah, 1983:5)

The concept of the CHW was viewed by the WHO as a unique element in primary health development, representing a bridge between communities and health systems. Being members of their communities, CHWs were able to identify community problems and those who were at risk and in need of care. They were conduits for health service information and agendas, providing preventive and promotive services in addition to medical treatment and tackling the causes of ill-health in their communities. They would also pass information about their communities back to health services, which would help in the planning and development of community health services.

That community health workers would be able to forge strong links with community members in order to perform these tasks was paramount. As Halfdan Mahler said in his speech quoted at the outset of this thesis, community health workers should take part in all the triumphs and tribulations of the people they served. It was understood that in order to be effective in advocating services and promoting broader development goals, CHWs must generate and maintain strong networks of relationships both with their communities, and with the health system:

Thus, the networks of relationships and supporting systems on both sides are essential to the effective functioning of the CHW. If the CHW does not function effectively, this is more likely due to failures in these relationships than in the more immediate activities of the CHW. (Ofosu-Amaah, 1983:5)

It was on health workers' relationships with their communities that their success or failures would rest. In forging these relationships, health workers were not expected to limit their focus to promoting health service agendas, but rather to fully integrate

themselves, promoting the interests of those the communities they served and advocating broader social and economic change. The 1978 conference report indicated the potential of CHWs to promote broader social and development goals, and suggested that country health systems should support them in this regard:

[Health systems] can play a wider role in the training of health workers by showing them how to function in harmony with workers in related social and economic fields for the common purpose of development. (1978:45-6)

The concept of the community health worker was one of the most powerful visions to emerge from the dialogue on primary health care, offering a means to widen access to health services at reduced cost, whilst acting as bridges between communities and health systems and supporting broader development agendas. Yet as much as the idea of the CHW had captured the imagination of national and international health policy makers, understandings of how they might operate to best effect were less well developed. Some saw CHWs as panaceas which would solve a full range of complex health and development problems, placing a great deal of pressure on newly trained health workers. Some viewed them primarily as political actors who could create pressure for social change, whilst others neglected the 'bridging' function of the CHW, focussing only their technical role as health service providers (WHO, 1989).

These discussions of the role of CHWs took place in the broader context of debates about the nature and viability of the vision of primary health care that had been presented at Alma Ata. For some, PHC became a by-word for a response to the demand for social justice and equality, whilst some focused on the need to expand the coverage of basic health services. For others, PHC denoted a holistic approach which meant incorporating educational and agricultural projects into the provision of health services (Litsios, 2007). At the point at which discussions were taking place as to the role of the community health worker and how to implement primary health care, the debt crisis of the 1980s took hold, dramatically changing the direction of international health care policy once again.

The debt crisis, neo-liberalism and a second shift in health care approaches

Even as the WHO was attempting to implement Mahler's vision of primary health care which called for redistribution of wealth and power, many developing countries were being compelled by the international financial institutions to whom they were indebted to implement market-led economic policies. The economies of newly formed states relied in the large part on the export of primary commodities to the west, trade relationships which were often adverse and did not generate the necessary funds to import the goods and technologies required to develop their economies further. This generated a vicious cycle in which the governments of developing countries were compelled to rely on investment and loans from the governments of developed countries and international financial institutions in order to finance economic development. In order to repay increasing levels of debt, more trade of primary commodities was necessary, which in turn required further borrowing.

This trend was highly deleterious for the economies of developing countries, especially when the recession hit in the late 1970s as a consequence of spiking oil prices and soaring interest rates (Saad-Filho, 2005). Unable to continue to invest in production, poorer countries faced an immediate reduction in export demand, declines in commodity prices and unmanageably expensive debts as the interest rates on the flexible loans taken out by the governments of developing countries rose to inordinate levels (Segall, 2000). As these countries began to default on their loans, commercial financiers withdrew a large amount of the capital they had invested, and demanded that western governments find a way to ensure that the debts of developing countries were recovered.

The Washington consensus and health care: from human right to commodity

Propelled by pressure from the Reagan and Thatcher administrations, the IMF and the World Bank developed the so-called 'Washington consensus', which promoted neoliberal policy prescriptions for poor countries. The 1980s saw the rise of neoliberalist approaches to development, which viewed the economic crisis in Sub-

Saharan Africa as a product of government intervention, and required countries to cut back public spending and open up markets to free trade. The IMF and the World Bank developed macroeconomic stabilisation strategies which were based on the imposition of lending conditions designed to significantly limit public spending in developing countries. These 'structural adjustment programmes' were made conditions of providing financial aid to Sub-Saharan Africa, and demanded that liberalisation and privatisation policies be implemented in order to stabilise economies and allow market forces to operate.

The impact on state provisioned health services was devastating. The cut backs in public spending were severe, especially in non-productive sectors such as health care. According to Stuckler et al (2008), countries which implemented an IMF structural adjustment programme experienced approximately an 8 percent drop in public spending as a percentage of their GDP, which had a profoundly damaging impact on the provision of health care services and the number of physicians available to the populations of those countries. In addition to limiting the reach and availability of health services, the Washington Consensus also signalled the rise of a very different perception of health care, which in contrast to the WHO's vision of health as a human right, saw health care as a commodity which could be regulated by the market.

These changes were accompanied by a decline in the influence and power of the WHO which struggled to maintain its authority during the period of structural adjustment, and the expansion of the World Bank into health policy development (Ruger, 2005). Originally formed post-war to aid in the reconstruction of Europe and later expanded to offer financial assistance to support developing countries improve their infrastructure, in the 1970s the World Bank began to invest in projects addressing health and education. Their expanding role in developing health systems was cemented in 1979 when the bank formed a department for Population, Health and Nutrition which offered financial support for health programmes. Godlee (1995:182) describes the WHO as having entered a 'cycle of decline' in which they were unable to garner support for comprehensive health care reforms, and did not have the power to respond adequately the international political economy which was undermining the values they had set out in 1978. The World Bank emerged as the leading provider of health programme funding, and prioritised projects which reflected the goals of neo-liberal development.

The Bank's approach was to encourage the introduction of user fees, which required patients to pay for the use of state health services. As outlined in their 1987 report *Financing Health Services in Developing Countries*, this policy was intended to generate funds for health services, and encourage people to make use of lower cost primary facilities rather than visiting hospitals. Funds from expensive, urban health facilities would be used to subsidize rural clinics. Health ministers of many African countries participated in The Bamako initiative, a programme which promoted health sector decentralisation, whereby health services and payment systems would be managed at a district level by community organisations. Although the impact of user fees varied in different countries, overall there was a significant decline in the number of people seeking treatment at state facilities (Woodward, 1992).

Amongst the poorest communities, even low user fees were unrealistic, and many patients went without treatment, or visited traditional healers. Evaluations of the Bamako initiative raised serious concerns about equitable access, suggesting that community associations were not adequate safety-nets for the poorest who could not afford to pay, and excluded access to maternal and child health services for those whom the policy was designed to target (Jarrett and Ofosu-Amaah, 1992). Whilst the World Bank had predicted that user fees would cover up to a fifth of the costs of running medical facilities, the income generated was so low that in some countries the cost of administering user fees exceeded the income they produced (Yates, 2006). The period saw a decline in child immunisations, and the return of diseases such as yellow fever which had been all but eradicated during the programmes of the 1960s (Vickers, 1991).

The economic crisis and health sector reforms of the 1980s also had a severely detrimental effect on community health workers, lowering quality of services they were able to offer, and destroying morale. Health services put enormous pressure on community health workers, requiring them to increase efficiency whilst cutting the running costs of community clinics. In order to satisfy the demands of health services and managers, health workers were forced to reduce the quality of services that they offered to their patients. This resulted in what Segall (2000:65) has referred to as a 'clash of cultures' between their public service ethic and the culture of the market, which left front-line health workers alienated and demoralised. Standing and Chowdhury (2008) have discussed the challenges for community health workers

operating in pluralist, market-led health systems and found that the volatile nature of changing markets and technologies requires health workers to be adaptable under difficult circumstances, and also generates new inequalities in access to health care. In particular they point to the difficulties that can arise when community health workers are put under pressure to conform to multiple agendas, particularly where their roles as community members and agents of the government health system are in conflict.

The decline in health sector spending precipitated a deterioration of community health facilities and equipment, and shortages of all drugs and supplies, leading to a rapid decline in the quality of services on offer. The poor quality of services combined with the introduction of user fees resulted in a significant reduction in patients' use of the facilities, especially at the level of the community clinic. Meanwhile, health workers experienced a considerable drop in the real value of their salaries, to the extent that they were no longer able to afford basic household goods (Noormahomed and Segall, 1994). Cases were documented in which health workers became abusive towards patients, or pressured them into paying additional, under the table fees (Lewis, 2007). Many more health workers undertook additional private practice in their communities, with some offering unregulated and unlicensed services.

The concept of the community health worker had its roots in the notion that communities had a right to health, and should be served by health workers who had their best interests at heart. Yet not ten years after community health workers became the pinnacle of the primary health care movement, they had come to represent the decline in community health services, undermining community values, and attempting to top up their derisory salaries through turning to private practice.

Morales-Gómez (1999:102) notes that the marketization of public services fundamentally undermined 'social safety nets' for the poor, and that in the attempt to find feasible solutions, governments diverted resources from social programmes to the private sector. In some cases, health workers were actively encouraged to seek alternative employment in the private sector. In this way the basic needs approach of the previous decade was reformulated such that the responsibility for survival was transferred to the poor and their communities, a trend generated by the desire of international financial organisations to improve the efficiency of social provisioning. Now, health sector policies focused on supply-side financial reforms, at the expense

of the community-based, primary care initiatives advocated by the Alma Ata Declaration.

Selective primary health care

The failure of the World Bank's user fees policy to generate the necessary income to fund medical facilities combined with severe cuts in public spending led to mounting criticism of structural adjustment programmes. By the late 1980s, UNICEF and the UNDP had begun to gather evidence of the detrimental effects of the Washington Consensus on health care, noting that family incomes in sub-Saharan Africa had fallen, and that the health of the poorest people was suffering the most as a result. In 1987, UNICEF published a report which concluded that human well-being should be a key concern in decision making during the recession, and advocated an approach termed 'adjustment with a human face', which would market low-cost, widespread preventive measures such as oral rehydration which suited the economic climate:

The expansion of ORS use and ORT action have, in most countries, taken place against a backdrop of cutbacks in finance and often staff for health and education. This movement against the downward economic financial trend implies an important restructuring of priorities and policy towards low-cost, mass application, often preventative measures – of exactly the sort which are needed even more urgently at times of economic difficulty and austerity. The challenge of 'Adjustment with a human face' is primarily to generalise these approaches over the whole field of basic human needs and to incorporate these actions into a macro-economic strategy which ensures their long term support. (UNICEF, 1987)

It was at this point that primary health care returned to the forefront of international health care policies, albeit in considerably modified form. As calls for economically viable programmes mounted, UN agencies, private and governmental organisations began the work of reducing the declaration on Primary Health Care to a more manageable set of interventions, which would become known as "Selective Primary Health Care" (SPHC). The lack of clarity regarding the implementation and financing of the concept of primary health care had left it vulnerable to more narrow interpretations, and the new primary health care focused on the practical side of health care provision, emphasising the need for targeted, low-cost interventions that

could be monitored and evaluated by the attendant organisations, including USAID, UNICEF and the World Bank.

The vision of primary health care presented here was not one of health as a human right and as a transformative system, but a much narrower set of interventions which primarily entailed growth monitoring, oral rehydration, breastfeeding and immunisations, known as known as 'GOBI' (Brown, Cuto and Fee, 2003). These instrumental strategies in many ways marked a return to the 1950s approach which emphasised low-cost interventions rather than long-term health system building, a fact which UNICEF acknowledged itself some years later (UNICEF, 2006).

The ideal model of the World Bank's Health Care Reform is captured in the 1993 World Development Report *Investing in Health*, which focuses on the relationship between health and economic development, examining the impact of public finance and policy on the health care arena. The report advocates health care approaches based on the requirements of economic growth strategies, which mainly entailed cost-effective programmes that focused on disease control. This marked a profound reformulation of the concept of primary health care, in which the need for low-cost interventions and measureable results quickly obscured the desire to promote social change using a holistic approach to community health (de Rivero, 2003).

Whilst the selective primary health care programmes promoted by the World Bank did much to improve child survival rates through targeted immunization and rehydration campaigns, it did nothing to address the weakness in the public health sectors of the countries in which these campaigns took place. Training of health care professionals, provision of national medical supplies and the scope and reach of primary health care services were not widely improved, leaving a weak infrastructure which undermined efforts to maintain the momentum of targeted interventions. The modified neoliberal version of primary health care also narrowed the roles of health service providers and recipients, such that the transformative agenda which underpinned the original concept of primary health care was all but eliminated.

Health workers and seekers under SPHC

The primary health care movement had recognised that achieving 'health for all' required policies which addressed the social and economic conditions which

determined health status. The health sector alone could not address the causes of ill-health, and a wider engagement development issues was required. At the heart of this approach was the principle that the poor and marginalised should be provided with the means to address the structural causes of poverty, inequality and ill-health. The active involvement of individuals and communities in the design and running of health services would ensure that health services met their needs, and provide opportunities for communities to engage in the wider development process (Rifkin et al, 1988). Community health workers would act as conduits for multisectoral development, representing community interests to health services, and encouraging their communities to become involved in broader development processes. Under this model, health workers and the members of the communities in which they worked could become dynamic participants, with platforms from which they could challenge inequality and play an active role in the development of health systems.

Yet, as with understandings of primary health care as a whole, the concept of community participation came to be understood and deployed in different ways by different stakeholders, in some cases legitimating a very different set of practices than those which were intended by, for example, the architects of the primary health care movement (Cooke and Kothari, 2001). Under SPHC, the return to technologically-based, instrumental health care initiatives obscured the element of primary health care which addressed the structural causes of ill-health, and limited the opportunity for community involvement. Within the market framework, health care had become a commodity, and consumer-led policies limited the definition of community participation to that of a means to improve the acceptability and efficiency of health services (Asthana, 1994).

The World Bank pursued approaches which solicited civil society participation in service development on the basis that community knowledge and resources would help build a more efficient system:

...local governments are increasingly requiring some payment by users for investment and services. When that happens, the role of citizens is transformed from passive beneficiaries to that of key decision makers — if the consumer does not participate by paying in one form or another, the flow of services will cease. If citizen consumers are not provided with a role during the identification of potential investment in services, local governments run the risk that citizens will disengage

following completion of the project investment phase. Citizen participation is best encouraged by identifying the groups that will need to be involved in financing and managing the post-project flow of benefits and working back from that perspective in order to involve those same stakeholders in the project design and implementation phase. (World Bank, 1996:3)

In this way the new model of community health care instrumentalised community participation, obviating the elements which would have encouraged local people and organisations to engage politically with community health systems and development. Community members were constructed as consumers, and participatory processes were designed to identify those who would need to be wooed in order to facilitate successful implementation, overlooking those who had little power or resources for community decision-making. National and international economic policies which viewed education and health as marketable services were being reproduced at a regional level, leaving little space to address the structural causes of poverty.

Cornwall and Gaventa (2000) note that market-led conceptions view the clients of social welfare as consumers whose participatory role amounts to the choices they make when selecting the services they use, rather than as one of active participants who engage in the formulation of social policy and provisioning. Under SPHC, the move towards engaging community members in the provision of services remained embedded in a top-down logic which viewed professional policy makers as ‘experts’, where clients have little means to engage with the policy making process beyond making consumer choices.

Just as community members had their participation limited to that which was required by the market model of health service delivery, so too were the roles of health workers constructed only in so far as was considered necessary for maintaining the delivery of basic primary health care services. The directive for encouraging broader social change through community health programmes was side-lined in favour of supplying health workers with much narrower roles of improving child health and nutrition through targeted, low-cost interventions. Having begun as a two-pronged approach which combined service provision with a more transformative agenda, primary health care now focused more narrowly on the provision of basic services which would produce measurable results, at the expense of the advocacy work in which health workers were to have taken part.

One of the most detrimental effects of this approach was that attention was focused on technological interventions, rather than the potential of health workers to shape community health systems for the better. It also obscured the activities, strategies and understandings of community health workers which play a pivotal role in determining the outcomes of health interventions. As Walt and Gilson (1994) argue, focus on policy content diverts attention from the actors who deliver health services, and neglects the processes involved in implementing policies, a greater understanding of which could help explain the successes and failures of health interventions.

The impact of the return to instrumental measures and the failure to harness the potential of community health workers was highly detrimental in many areas, yet SPHC had a uniquely devastating impact on maternal health. This area of health care suffered a dual blow through the failure to invest in strengthening health systems needed to provide adequate and timely maternal health care, and through the narrowing of the role of community health workers who had the potential to advocate women's rights to reproductive and maternal health services both with their communities and with health systems. Throughout the process of health system reforms, explicit discussion of women's health and rights has been almost entirely absent from mainstream policy making processes, the legacy of which can be seen in the fact that progress in reducing maternal mortality lags far behind advancements made in other development goals.

I now turn to an overview of the ways in which health policy reforms have neglected and affected women's health and reproductive rights, and examine the emerging discourse on integrating broader social goals with the provision of clinical maternal and reproductive health services. I conclude by arguing that the feminist approaches to health outlined below highlight the importance of a renewed focus on the capacity of community health workers to play a transformative role in their communities, advocating women's health and rights.

Maternal health care and women's right to health

There is no doubt that the implementation of primary health care systems in developing countries has been advantageous, especially in the areas of child health and disease control. Yet there remain considerable deficits in the design of primary health

care which profoundly affect the delivery of maternal health care services. This area is uniquely and adversely affected by the constructions of primary health care which have emerged from conversations post-Alma Ata. Today, the overall maternal mortality ratio for developing countries is 230 per 100,000 live births; the ratio for Sub-Saharan Africa is 510 per 100,000 live births - the highest in the world (WHO, 2014c). These statistics rarely include morbidity rates, which are much more difficult to measure. It is estimated that for every woman who dies in childbirth, there are 20 others who suffer serious, often debilitating complications, which can lead to increased chances of mortality in subsequent pregnancies (UNFPA, 2014). Mortality rates remain highest in rural areas of SSA, where access to health care facilities is limited. Although there has been a significant reduction in maternal mortality rates on a global scale, many countries in SSA are characterised by the WHO as making 'insufficient progress' or 'no progress' in this area.

When asking why rates of improvement in maternal mortality fall so far behind those of other development goals, it is necessary to examine the way in which this area of health care has been addressed in the development of primary health care systems. The most marked trend which has persisted throughout periods of change in visions of primary health care is the tendency to view maternal and child health as an encompassing health care and policy issue which should be thought about as a whole; that which is good for the child is also good for the mother. A further impediment to considering the health and rights of women independently is a long-held 'silent assumption' that because women are at the heart of primary health care processes as community health workers, household caregivers and recipients of health care, gender concerns are necessarily being addressed (Mackintosh and Tibandebage, 2004). The large number of references to gender and emphasis on maternal and child health in the selective primary health care literature serve to obscure the fact that women's experiences of poverty and power are not present in policy frameworks.

Writing in *The Lancet* in 1985, Rosenfield and Maine asked the question 'Where is the M in MCH?', noting that the majority of measures introduced in this area addressed child health and neglected the causes of maternal death. They highlight the policy blind spot created by viewing maternal and child death in conjunction, pointing out that both the causes of maternal and child death and the remedies required are very different. The neglect of maternal health care can be explained in part by revisiting the

debates over how primary health care should be viewed and administrated. The development of ‘selective primary health care’ advocated widespread, cost-effective approaches to health care, which could be administrated by streamlined, efficient primary health care services. In the area of maternal and child health, this meant that the focus was primarily on targeting childhood diseases via immunisation programmes, and improving nutrition with oral rehydration and breast feeding campaigns, in addition to food supplementation.

These measures employ low-cost technologies which are hugely beneficial to improving the health and life expectancy of children, but do little to improve maternal health. Indeed, after the 1984 Bellagio conference on improving child health, the major players in developing primary health care including UNICEF, WHO, the World Bank and the Rockefeller Foundation all declared that child immunization was the single most important intervention of those developed by UNICEF to target maternal and child health (Basilico et al, 2013). One key intervention which was specifically targeted at women was family planning, a low-cost strategy widely advocated since UNICEF’s SPHC interventions in the 1980s, designed to address growing populations and address maternal mortality.²

From population control to reproductive rights

Advocates of UNICEF’s programme argued that there is a clear and measurable link between uptake of contraception and reduction in unwanted pregnancy and maternal death. Promotion of family planning would therefore significantly reduce maternal mortality rates using low-cost technologies which did not require significant developments in health care infrastructure in order to deliver. Yet the way in which family planning has been viewed and implemented in the context of broader health and population policies constitutes a legacy in which women’s reproductive rights have been systematically marginalised and abused. From the 1950s, the prevailing view was that population growth was a serious detriment to economic development and public health, and on that basis many governments implemented “population control” policies designed to promote family planning and lower birth-rates. Family planning became the key technology via which the ‘population problem’ was to be

² In addition to their GOBI program which implemented child growth monitoring, oral rehydration, breastfeeding and immunisation, UNICEF introduced basic interventions designed to improve maternal health, which advocated family planning, birth spacing and food supplements.

addressed, and after the creation of the UN Population Fund (UNFPA) in 1969 population programmes and family planning programmes became nearly synonymous (Ashford, 2001). The notion of population control became mainstream in 1984 after the World Population Conference in Mexico City, where it was declared that governments should make family planning services universally available “as a matter of urgency”.

It has become apparent through a general analysis of trends in health policy that historically there has been an abiding assumption that approaches which were considered desirable in the development of western medicine and society should also be considered desirable in health planning in developing countries. This trend needs to be re-examined in the context of women’s reproductive health, where campaigns in the West to further women’s access to family planning services have translated very differently as they have merged with the population control policies which prevailed in the 80s and 90s for developing countries. Smyth (1998) warns that where in the West access to contraception was viewed as a key source of liberation and sexual freedom, modern contraception and the programmes which manage it in developing countries have often undermined women’s physical and social wellbeing.

As population control became a key agenda, women in many countries including India, Bangladesh, Nigeria, South African and Brazil have faced forced sterilisation (Hartmann, 1995), whilst others have been pressured into the use of contraception without adequate information or appropriately trained health care personnel being made available to them (Jejeebhoy, 1995). Where government-led population policies attempt to regulate family size through promotion of contraceptives, direct and indirect penalties have often been implemented in the name of advancing economic development and improving maternal and child health. Such measures have the greatest detrimental impact on the poorest and most vulnerable women, inequalities which are obscured when viewed through the lens of population control.³

While population control measures were being lauded as a means to lower maternal mortality rates, women’s health and rights advocates began a sustained attack on the fundamental bias in the architecture of health policy which reduced complex

³ Population control policies have long been linked to the killing of female infants in order to satisfy the desire for sons whilst adhering to the family size limits determined by state mandate or by necessity in the wake of state-led health sector reforms. cf. Sudha and Rajan (1999); Banister (2004).

gendered, social and political systems to an issue which could be addressed using fertility control measures (Corrêa and Reichmann, 1994). Of particular concern was the instrumental approach underpinning selective primary health care, a trend which had a particularly detrimental effect on the women whose reproductive health is at stake. Critics of population control policies argued that the instrumental approach fell far short of a comprehensive system of maternal health care which focuses on enhancing women's health and rights.

Instead, it was deeply ingrained in health policy frameworks that population was the 'problem' and family planning was 'the solution', the implication for many being that women as child-bearers were at the heart of the problem. As Kabeer (1994) points out, women were seen as the cause of population problems, and therefore as the potential solution. This approach obviated the need for improved health care infrastructure, whilst obscuring women's bodies as the site of the reproduction of development discourse and power (Richey, 2004).

In response to this deleterious trend, women's health advocacy groups around the world joined to highlight the population programmes which emphasised targets and quotas whilst undermining women's reproductive rights and the quality of health services available. At the 1994 conference on population and development in Cairo, women's health advocates asserted that family planning programmes would be more effective if they took the social and cultural context of use of contraceptives, pregnancy and sexual relations into account. They proposed that concepts of reproductive health and rights be incorporated into population programmes, and it was agreed that the scope of existing population policies be enlarged to accommodate promotion of health, education and rights, and to ensure that family planning services were delivered through a programme of comprehensive reproductive health care.

The Cairo conference marked a turning point in approaches to reproductive and maternal health, in which family planning was no longer promoted in isolation as the solution to population control and maternal mortality. In 1999, the UN defined reproductive health for the first time, stating that reproductive health care should enhance individuals' rights. A key policy concept to emerge from this change in thinking was that of 'unmet need' for family planning, which refers to situations in which women want to avoid or postpone pregnancy but do not have access to

contraception, and has become a central means through which to discuss and plan interventions.

Whilst the notion of unmet need originated in the population surveys of the 1960s, it gained much currency in the 1990s alongside the shift in thinking towards women's individual rights and fertility desires, on the basis that it combined both reduction in fertility and the "social component" which addresses the rights of individuals, and acknowledges social barriers such as opposition from husbands and communities, and health concerns (Casterline and Sinding, 2000). Tackling unmet need is now a central part of the health services provided by rural clinics in Sub-Saharan Africa, and the training of health care personnel in the administration of various forms of contraception is considered a high priority (WHO, 2011).

Feminist perspectives on maternal health

As debates about population control were highlighting the need for a shift in thinking towards women's health and rights, so too were maternal health advocates, who criticised the marginalisation of women in MCH campaigns. In 1987 the neglect of maternal health in maternal and child health initiatives was acknowledged at the first International Safe Motherhood conference in Nairobi, where delegates called on international programmes and heads of state to address the issue of maternal health head-on. Noting that initiatives for improving maternal health were often a by-product of child survival efforts, the conference marked the beginning of the safe motherhood initiative, through which women's advocates called for women's health to be addressed in its own right and on a systemic level.

A key issue highlighted by the campaign is that donor agencies have consistently favoured vertical programmes which focus on single targets such as training birth attendants, which are not sufficient in addressing the broader causes of maternal mortality. They argued for a coherent set of interventions which would provide complete health care and support for women throughout pregnancy and delivery. This included making emergency obstetric care - including trained personnel, medications and equipment - available to women in a timely way. In order to bring about these changes, it would be necessary to develop health systems and

infrastructure as a whole rather than focussing just on low-cost interventions which do not require structural changes.

Advocates of women's health and rights also highlighted the need to address the deep inequalities which affected women's access to reproductive and maternal health care, both at a local level and in the formulation of health policies. At the International Day of Action for Women's Health in 1990, advocates declared that 'to cure the health problems of women is to acknowledge that oppression – and health problems – are not determined by biology, but by a social system based on the power of sex and class' (Araujo and Diniz, 1990). This was a significant milestone in thinking about women's health, establishing a clear link between the construction of health systems and the broader systems in which women's health and rights were marginalised. As Smyth (1998) has stated in her discussion of women's reproductive rights, a feminist perspective has meaning outside this specific area; it implies that those who hold this perspective desire a more complete political transformation of the system in which reproductive health, rights and population policies are produced.

Freedman (2005) has articulated the shortcomings of international policy approaches to maternal health care, arguing that current policy language continues to frame targets in technical terms which invite technical responses, setting up a system in which the political nature of social change is obscured from the start:

...behind the failure of health systems lies a deeper, structural crisis, symbolized by a development system that permits its own glowing rhetoric to convert the pressure for real change into a managerial program of technical adjustments. (2005:2)

She argues that the instrumental framework for health invites a top-down approach, with a linear progression of steps including determining the primary causes of disease, measuring incidence and prevalence, identifying the appropriate medical treatments, determining the most cost-effective delivery system, and garnering financial support for proposed medical interventions. Freedman advocates an approach which allows power to be marshalled to transform the structures of health systems which shape the lives of women and children. She emphasises the fact that women and children have vastly unequal access to health care interventions, and argues that ensuring that health care is accessible to all is not just a technical problem, but a political issue which requires sustained attention and investment. This argument is supported by the fact

that, despite regular objections to strengthening health systems for women on the basis of cost and complexity, the WHO has provided convincing evidence that developing strong maternal health systems is cost-effective and realistic with donor support for countries with high maternal mortality rates (WHO, 1999; Pathmanathan et al, 2003; Foster et al, 2013).

Maternal health advocates have highlighted inequalities both inherent in international health policy and those which limit women's access to health at a local level. There are many barriers for women in accessing health services, and maternal health advocates have made explicit the fact that pregnant women are particularly socially and economically vulnerable in a number of ways. Women incur significant direct and indirect costs associated with multiple pregnancies throughout their lives, requiring ante and postnatal care, midwifery services, medications and transportation to health facilities. They are often unable to access services due to the double burden of waged work and childcare (USAID, 2011a). Where women's education levels are low, understandings of maternal health care requirements may be poor. Where women have little control over household expenditure, they may not be able to access the necessary funds to cover the cost of health care (Gage, 2007). The poorest women are the most at risk of maternal death, often living a prohibitive distance from the nearest health facility, and unable to pay for the costs associated with care. As Filippi et al point out, 'increased, repeated vulnerability linked to gender makes maternal health a unique issue.' (2006:1536).

Integrating gender into community health care

The feminist approaches to reproductive and maternal health explored here have highlighted the need to create space within community health service provision for a component which addresses the rights of women and acknowledges social barriers to health. Such a component is vital in order to improve maternal health, as women are disadvantaged in numerous ways by social barriers when attempting to access maternal and reproductive health care. Calls to improve the way in which health systems operate for women gained support with the pivotal 1995 Beijing conference on women, which in addition to setting out the principle that gender equality concerns should be integrated into the formulation of all policies and programmes,

recognised that ‘the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment’ (UN, 1995:3).

Programmes with instrumental goals such as fertility reduction began to include feminist objectives such as ‘improving the status of women’, acknowledging the link between high fertility and women’s disprivilege (Richey, 2002). Community health programmes, including the CHPS programme in Ghana which I explore in detail later, have begun to expand the role of the community health worker to include educative and advocacy work, highlighting the importance of fostering community relationships to women’s health in a way that echoes the Primary Health care Movement’s view of CHWs. It is so hoped that integrated health programmes might ‘bridge the divide’ between instrumentalist policies and women’s rights over their health and bodies (Kabeer, 1993).

However, the ideal of providing health services to women whilst promoting rights and social development has proven to be difficult to implement in practice. Many integrated programmes have focused on instrumental, measurable ‘gender goals’ whilst marginalising explicitly feminist aspects which challenge relations of power and authority. Mukhopadhyay (2004) notes that much of the work in integrating gender equality concerns has focused on improving technical processes through frameworks, checklists and tools for gender integration, whilst transformative elements which challenge inequalities are rarely explicitly acknowledged. Further, programmes which incorporate social components such as educative and advocacy work often assume that these aspects will adequately meet the requirement to address gender concerns, and fail to articulate how these activities might be linked to enhancing the rights and opportunities available to women (Standing, 2007).

The enduring neoliberal framework in which health policy is formulated puts bureaucratic and political pressure on integrated programmes, causing them to morph to the point at which they reflect the technical agenda, and address women’s social and political concerns in name only. Cornwall and Brock (2005:1051) highlight the malleability of development ‘buzzwords’ such as ‘women’s empowerment’, and note the way in which they are diluted as they are deployed through development actor networks, obscuring the original emphasis on social justice and the reorganisation of power relations.

Studies assessing projects with multiple programme goals have often highlighted the key role played by field-level practitioners in influencing project outcomes and determining which goals are prioritised. Goetz (1996) has argued that one of the key ways in which fieldworkers ‘fracture gender policy rhetoric’ is by using gender policy to service other objectives, such as family planning or efficiency goals.

The experiences, strategies and understandings of field-level practitioners are crucial in determining the success or failure of attempts to integrate gender initiatives with the provision of technical services. Where projects incorporate ‘feminist’ or ‘empowerment’ agendas, fieldworkers have the power to enhance or undermine these elements through their interpretations and activities. Where programmes such as the CHPS programme in Ghana which call more generally for a social component to address the social causes of problems in delivery and uptake of services, fieldworkers have the capacity to develop their role to find ways to further women’s health and rights.

This is particularly true of community health workers, who are permanently based in their communities, and are often the only members of the health service with whom women interact regularly. They have a unique opportunity to engage in advocacy work, and promote the interests of women, their health, and rights in their communities. Yet their strategies also reflect both the constraints of the health systems in which they work, and the social barriers which they themselves experience. Understanding the way in which health workers’ day to day strategies can enhance or undermine women’s health and rights is a crucial step towards improving integrated health systems, and maternal outcomes.

The following section discusses the theoretical basis from which the experiences, strategies and understandings of health workers might usefully be explored.

Chapter 3: Constructing a theory from below: complexity for researching maternal health care

The campaign to improve maternal health care is profoundly influenced by the actions of those tasked with providing these services to their communities. The conversations they have, the community networks they generate and their understandings of the work that they do are crucial to maternal health care outcomes in the areas in which they operate. Community health care is about relationships, and no aspect more so than maternal health care where building trust and engaging with community understandings and traditions is of central importance. This chapter outlines the theoretical approach which underpins the research methodology and analysis of the data presented here. Whilst much of the research undertaken in the field of health care and development employs structural and institutional analysis (cf. Ostrom; 1995, Wagstaff and Claeson, 2004; Karlsen 2011), the approach outlined here is actor-oriented, and aims in particular to highlight the significance of the role played by health workers' networking practices in rural maternal health care contexts. It also aims to demonstrate the need for a theory which provokes greater understanding of the relationships and negotiations which underpin the everyday practice of maternal health care. The approach which emerges from this endeavour references a broad school of theorists who have in common the goal of finding a way to talk coherently about complex relationships as they are formulated and reformulated through the understandings and activities of a diverse range of actors.

The desire to move away from deterministic grand narratives and blueprints for social action towards theories which recognise the capacity of persons to transform their life-worlds is not a recent development, and has generated considerable theoretical and methodological advances in the fields of Development Studies and Anthropology (Booth, 1994; Long 2001; Mosse and Lewis, 2005). Despite this, whilst the need to approach maternal health care in development contexts from a community angle has been acknowledged, the power of the actions and understandings of health workers to affect maternal health care outcomes requires greater attention.

Theoretical basis

Maternal health care in both Mali and Ghana is primarily understood in terms of community relationships by those who practice it. This observation constitutes the lens through which the theoretical approach was developed, and opened up two lines of theoretical enquiry for the purposes of examining the practice of maternal health care. The first is that throughout my research in both Mali and Ghana, the nature of health workers' relationships with the communities in which they worked – whether they were formal, informal, strong or weak – and the ways in which these relationships were understood by participants, had great significance for the practice of maternal health care. The second concerns the fact that the concept of community relationships in rural health care as it is understood by health services and the development community fails to explain, and therefore fails to adequately harness, the nature of the connections that exist between communities and health service practitioners.

As the data explored later on shall demonstrate, the actors discussed here do not conform to the blueprint of health care relationships which has become the popular mode of transforming community-based health care, and yet nor do they lack meaningful connections in contexts where such health care relationships are largely unacknowledged by the health system. Actor-oriented theorists who have traditionally taken the understandings and connections generated by actors in development contexts as the focus of their studies must now contend with the fact that their tools of analysis – conceptions of social relationships and community networks – have taken on a new, concrete form whereby they have become an explicit feature of health systems themselves. As such, they have developed their own language for characterising and understanding community health care relationships. In other words, the tools of analysis have become the object of analysis.

This is a problem of modern knowledge which is by now not unfamiliar, especially for anthropologists who research modern organisations. Annalise Riles has said that 'one of the paralyzing insights of late-twentieth-century critical theory has been the understanding that there is no "outside" to our analyses, no position beyond our own knowledge from which we can reflect critically on them' (2000:26). It is important, then, that we acknowledge this issue in the field of development and health, where

blueprints for health care relationships and varying notions of networks are becoming increasingly popular tools with which to manage the provision of community health care services.

It is now necessary to examine the ways in which these artefacts are indigenously produced, and the impact they have on the provision of different kinds of health services. We must also attempt to understand these artefacts in the context in which they are produced, rather than the anthropological and theoretical contexts with which we are familiar. For example, the Ghana health service's conceptualisation of health care relationships as a tool to further the provision of community health care differs significantly from both anthropological understandings of such tools, and the understandings of health workers themselves who are part of the system itself. Acknowledging and investigating such distinctions is a necessary function of actor-oriented analyses in contexts where 'process perspectives' are increasingly defining development initiatives (Mosse, 1998).

In this chapter I argue that the provision of maternal health care produces distinct patterns generated by the actions and understandings of the health workers as they provide these services in their communities. It relies on a number of interlinked factors, resources and limitations which health workers must navigate on a daily basis; uniquely influenced by social, cultural, economic and political factors, the practice of maternal health care reveals much about the issues which affect its provision. Health workers draw on their own experiences, understandings and resources in order to develop strategies, and in doing so they produce patterns which tell a story about the provision of maternal health care.

These patterns constitute a form which we might use to view the way in which maternal health services construct and are constructed by those who work in these contexts on a daily basis. In approaching my subject in this way, I am taking forward the task with which Long (2001) has charged development theorists, that of identifying and clarifying actor strategies whilst paying particular attention to the conditions under which they arise. I am asking what about maternal health care in particular necessitates the strategies executed by the health workers whom I observed, and I require a theoretical approach which meets the analytical challenges presented by this endeavour.

This chapter is designed to bring into view certain analytical tools in the context of maternal health care in the rural areas of West Africa in which I worked. Whilst the theoretical concepts outlined below are not in themselves unfamiliar, they are reconstituted through their application in a unique context. As we shall see, the practice of maternal and reproductive health care in rural Mali and Ghana yields distinctive patterns which demand a re-evaluation of both our approaches to understanding community health care in these countries, and the broader tools with which we examine the role of public sector bureaucracies in developing countries.

The first part of this chapter sets up the broader theoretical context, that of the development of analytical tools designed to allow description of increasingly complex social phenomena, and the repositioning of the actor at the centre of analysis in development contexts. It examines the move towards observing development processes as they play out in everyday contexts, and the acknowledgement that the actions and understandings of local peoples can profoundly affect policy outcomes. From there, it goes on to examine the network tool as it has emerged from the desire of numerous theorists to grapple with the complexity of social relations, and provides a genealogy of the network form.

The second and third parts constitute a synthesis of theoretical forms which I have extracted for the purposes of putting them to work vis-à-vis the provision of maternal and reproductive health care. The focus here is on how networks and networking practices might be understood in the context of the policy and practice of maternal health care, and the insights the network form provides with regards to the lived experience of the provision of maternal health care services. If the ethnographic task I have undertaken here is to, as Norman Long (2001) puts it, ‘identify and characterise differing actor practices, strategies and rationales, [and] the conditions under which they arise’, then a theory is required which allows us to view these strategies in relation to the broader social, bureaucratic and political contexts in which these actors operate.

Here an argument is made for viewing the practice of maternal health care through network aesthetics, supported by both insights from theorists discussed above, but also informed by the emergence of formal and informal patterns of local health care relationships as a key characteristic of the provision of these services throughout my fieldwork. It brings together themes of brokerage and network ‘failures’ in order to

illustrate the way in which health workers shape and shaped by the health system of which they are a part. The guiding principle which emerges here is that in order to better understand the problems and successes of rural maternal health systems, it is necessary to develop what Long (2001) refers to as ‘theory from below’. In approaching the project in this way, the artefacts of maternal health systems such as local relationships, networks and understandings are taken as the central point of analysis, rather than the maternal health system itself. The argument here is that it is only by examining the everyday practice of maternal health care, that the system might be understood.

Actor-oriented approaches, ‘process’ and networks

The fabled ‘impasse’ in development in the 1980s highlighted a need to move beyond structural explanations and development solutions based on the received wisdom of western development agencies. The assumption that expert western knowledge was somehow superior was heavily criticised by those eager to highlight that the proposals presented by development professionals as objective means to human development often masked gross inequalities and malign political agendas (Hobart, 1993; Ferguson, 1994; Escobar, 1995). Yet in the context of wholesale deconstruction of notions of development, the question remained as to whether it was possible to have a meaningful discussion about development which included possibilities for social justice. Many seeking to move beyond the impasse have turned to forms of analysis which examine the everyday enactment of development processes, highlighting the understandings and relationships which underpin the practice of development. These actor-oriented perspectives call for those working in development to examine the social realities of those involved in development processes, acknowledging and finding ways to work with the complexities which emerge (Booth, 1994; Long, 2001; Kontinen, 2004; Yarrow and Venkatesan, 2012).

This is a viewpoint which requires detailed and nuanced ethnography that accounts for the self-transforming properties of the actions and understandings of those involved in the everyday practice of development. These practices are highly complex, often contradictory, and are contingent on the interests shared by actors across different organisations and social groups. As such, researchers must be aware of the extensive networks of interests and relationships that emerge from even the most

small-scale development context. From their entry point of examining the life-worlds of those involved in the everyday practice of development, researchers must also be aware of the ways in which these practices are connected to a multitude of international interests and understandings. The work of David Booth in particular was pivotal in influencing the way in which both the academy and development institutions themselves thought about processes of social change, posing a fundamental challenge to the structuralist solutions which had gone before. He urged those working in the field to give special attention to the way in which development processes were constructed, in order that they might bring into view the diversity of possible outcomes and the relations of power which underpinned development activities (1994). Taking forward the themes of power and agency, Long (2001) advocates a form of actor analysis that identifies the ways in which the power and meaning which guides human behaviour influence the creation and outcomes of multiple social forms:

We must encompass not only everyday social practice and language games, but also larger-scale institutional frameworks, resource fields, networks of communication and support, collective ideologies, socio-political arenas of struggle, and the beliefs and cosmologies that may shape actors' improvisations, coping behaviour and planned social actions (2001:4)

Examining development practices through observing everyday interactions requires us to acknowledge the multiplicity of notions of development itself as they play out before us. Development interventions have their own organising logic which determines both their intended and unintended consequences, and it is necessary to examine both elements if we are to better understand the challenges faced in any given circumstance. Indeed, the unintended consequences of development interventions have become central to the investigations of many researchers who have found that the un-planned consequences of development policies can profoundly affect project outcomes, and whilst yielding information which leads to greater understanding of the processes at work on the ground (Mosse and Lewis 2005; Olivier de Sardan, 2005).

One of the most instructive aspects of this observation is that it encourages examination of the everyday actions and understandings of those whose role it is to carry out interventions in any given field of development. Whether they are the front

line workers responsible delivering government services, or fieldworkers implementing development initiatives, those who work at the interface of service delivery play a critical role in determining project outcomes and the experiences of those who use the services on offer. Workers in this position are often endowed with considerable discretionary powers, and the exercise of this discretion structures the lives and opportunities of those who interact with the agencies for which they work.

Writing on the pivotal role played by the discretion employed by public service workers, Michael Lipsky (1980) notes that although front line workers are often regarded as low-level employees, it is their actions that constitute the services offered by the government. The individual decisions taken by these employees based on their own understandings, attitudes and experience amount to agency policy, and can have a significant impact on the lives of those who use public services. Not only do public sector workers exercise relatively high degrees of discretion, they also often have a considerable degree of autonomy from the organisations for which they work. Lipsky examines the role of public sector workers including teachers and health workers, observing that the ways in which they carry out their roles significantly ‘structure and delimit people’s lives and opportunities’ (1980:4). As such, their actions shape the social and political contexts in which people act.

As community-level public sector workers, the health workers at the centre of my research are in a position to significantly shape the realities of those living in the communities to which they are posted. As my analysis of their activities shall demonstrate, they have a considerable capacity to impact health outcomes in both positive and negative ways. Living and working in their communities, they are often the only contact people have with the health service, and they use significant discretion in deciding the treatment individuals receive, the advice they give regarding contraception and relationships, and the level of interaction they have with community members. In addition, in the contexts in which I was working in Mali and Ghana, health workers themselves often have minimal interaction with the health services of which they are a part, having sporadic contact with health service administrators and receiving little supervision. For this reason, the relative autonomy from organisational authority to which Lipsky refers is compounded under these circumstances, highlighting the need to investigate the actions and interpretations of health workers in these contexts.

The relative lack of oversight provides health workers with a level of autonomy under which they are able to maintain different values and goals to those held by the health services to which they belong. For example, in the district in which I worked in Ghana a CHPS programme priority was ensuring that a certain number of families received home visits, yet the priority of many health workers was to ensure that visits were necessary and effective rather than carried out simply to meet the numbers directed by the health service. As Lipsky points out, street-level workers may consider the rights of managers to provide such directives to be legitimate, but they may well consider their managers' policy directives to be illegitimate and employ their own discretion when approaching these tasks.

Whilst emphasising the magnitude of the discretionary powers wielded by street-level workers, Lipsky also points out that these workers often shoulder considerable case-loads with few resources and ambiguous or unattainable service goals. This is a key point to make with regards to the contexts in which I worked, in which the strategies employed by health workers were often a product of the severe constraints under which they operated. The decision whether to carry out home visits on a given day was in many cases determined by clinic patient load, and lack of resources. Similarly, the decision to see a patient at their homes outside of the formal health service mandate was in many cases a response to health service inadequacies, and deleterious social norms and values.

That front-line service workers often operate under severe constraints balancing their responsibilities to both their clients and the government agencies who manage services they provide is often overlooked. Writing on good government practice in Brazil, Tandler (1997) responds to the widespread denigration of public sector services and argues that the dedication of front-line service providers such as health workers often working under difficult condition is crucial to responding appropriately to community needs. Taking good government performance as the point of departure, she asks what patterns and behaviour generate successes in several different government service contexts, a question which is central to understanding what role health workers can play in improving community health services in the contexts in which I was working.

In her work examining a preventative health programme in Ceará, Tendler describes the successes of the programme which ensured that health agents with basic training were available in each community, visiting families at home, administering vaccinations and offering advice regarding prenatal care, oral rehydration breastfeeding and growth monitoring. She notes that in the eyes of received wisdom on development at the time, a programme in which the majority of expenditure went to fund thousands of low-skilled health workers would have been viewed as a 'rent-seeking nightmare' (1997:22). Yet despite the prevailing view that large government programmes with significant work forces were costly and inefficient, the Ceará case demonstrated the profound benefits of making large numbers of low-skilled health workers available in communities.

Tendler argues that the health workers who conducted home visits and community events were highly visible, and did work which made them popular in their communities. They came to represent a crucial link between communities, local governance and the state, ensuring a productive balance between centralized control and local embeddedness. Further, through their multiple interactions with community members, health workers built more informed and demanding communities who became invested in maintaining the preventative health programme, and politically engaged with local governance.

The points raised by Tendler with regards to the capacity of health workers to generate a more informed and politically invested community are central to exploring the potential roles that can be played by community health workers. The community health programme in the district in which I worked in Ghana is a particularly interesting case study in this regard, demonstrating both the potential of health workers to connect with community members to improve health behaviour, but also the limitations experienced by health workers in this context which prevent them from engaging community members on broader subjects of social change and political engagement with the provision of services. Tendler describes conditions in Ceará under which the engagement of communities in the prevention programme placed political pressure on municipal politicians to support the programme. In contexts such as the CHPS programme in Ghana in which increased health service presence in communities does not significantly increase engagement with the politics of service delivery, it is necessary to investigate the conditions under which health workers are

performing their roles in their communities. I argue that examining the strategies of community health workers as a product of the conditions in which they are operating reveals much about the structural factors which open up or diminish opportunities for improved health care and political engagement with health services.

In cases where such individuals are required to uphold a model of development, particularly through scheduled targets and activities, it has been found that they often substitute the required practices for those which reflect their own understandings of the context at hand, especially where they are unable to meet the demands of the policy in practice. Notably, David Mosse's experience working with a DFID-led project in India led him to invert the traditional conceptualisation of policy and practice, arguing that policy can in fact arise out of practice where development actors mask the gap between the two by making it appear that they were upholding the policy model. He observed that the informal everyday practices of project workers routinely contradicted the prescriptions of official policy, substituting bureaucratic rules and targets for the anticipated self-reliance of the different autonomous spheres of fieldworkers, managers, consultants, the village and the office. Here it was not possible for policy models to orientate practice, yet staff, including consultants and local people, worked to protect official interpretations of actions in order to ensure that the project appeared to match the policy framework and was considered successful.

Mosse concluded that the reality of the situation was that his role as a long term consultant, whilst appearing to assist development operations, in large part served to produce and sustain policy models by offering an authoritative interpretation of events that resulted from very different logics. In this case the expertise which is reproduced in policy documents does not precede action, but follows it, and it is through such discourse that unruly practice is legitimised and the gap between policy and practice 'negotiated away'. In an earlier work he observes that '[Development agencies] are powerful institutions whose knowledge systems constantly organize attention away from the contradictions and contingencies of practice and the plurality of perspectives (Mosse, 1996:938)'.

Actor-oriented approaches are considered by many working in anthropology and development to be invaluable for the insights they provide into the field-level

understandings, negotiations and relationships which influence the lives of those with whom they work. Such approaches serve to highlight the social connections, communication, strategies and interactions with wider societal structures on the part of individuals which influence social outcomes. An actor-oriented approach to research permits an analysis which takes into account the multiple factors and linkages which produce social phenomena, and demonstrates the power of these linkages to generate or undermine the opportunities available to actors. For the purposes of researching maternal health care in the communities in which I worked, an approach which recognises the dynamic nature of these relationships and the way in which they can affect maternal outcomes is essential. Further, actor-oriented approaches have the advantage of linking broad social phenomena such as the experiences and environments of actors, their interactions with other actors and institutions and the larger outcomes which are influenced by these interactions, in ways which allow us to view these processes side by side. The contexts in which this research was conducted demand an approach which allows multiple factors and social phenomena to be viewed through the lens of community maternal health care provision.

Yet in taking such an approach forward to examine the actor strategies which underpin the provision of maternal health care it is necessary to examine the potential difficulties which may be posed by an actor-oriented analysis. Taking the actions and understandings of its subjects as the entry point for analysis, actor-oriented approaches have attracted criticism for advocating individualist explanations of human behaviour at the expense of examining the influence of development policies and structural inequalities. The neglect of power relations is the most pressing accusation which needs to be addressed; Gledhill (1994) argues that the benefits of eschewing structural-functionalist approaches is limited whilst the alternative fails to acknowledge the profound influence of broader factors on the opportunities available to actors. In privileging the agency of actors involved in negotiating localised processes, such approaches risk over-estimating the capacity of actors to 'absorb and rework extra local initiatives' such as institutional and cultural principles which shape their experiences (Masaki, 2006:25). Viewing actors as dynamic architects of their own realities can disguise the ways in which their experiences and understandings are limited by broader structural influences, and in taking their realities as an entry point, such approaches can direct attention away from these influences.

Actor-oriented approaches have been viewed as attempts to resolve the tension between the power exerted by societal structures and the power inherent in the exercise of agency on the part of human and non-human actors. According to Clegg (1989), analyses such as Giddens's structuration theory in which the role of agency is privileged over that of structure explains away the tension between the two with the assumption that localised actors ultimately have the capacity to translate broader societal influences. Such an approach impedes investigation of both the wider power dynamics at work, and the potential of field level actors to influence these overarching processes themselves. Approaches which fail to acknowledge these elements risk becoming what Olivier de Sardan (2005:12) refers to as 'closed circuits', in which analysis reproduces its own internal logic at the expense of illuminating different perspectives.

Yet one of the key observations made by many proponents of the approach, and one of the central guiding principles for my own analysis, is that we should not understand human behaviour in terms of individual interests, but rather acknowledge that persons and the institutions with which they interact are mutually constitutive. In particular, Norman Long's work in Peru and his subsequent writings on actor-oriented approaches serve to highlight the importance of combining understanding of individuals' actions and understandings with analysis of social structures, power relations and political and economic factors (Long, 1984, 1989, 1992, 2001). He argues that in order to centre our approach on human agency it is necessary to acknowledge the life-worlds in which they exist, including the institutional constraints that they encounter and their approach to dealing with issues which arise.

The need to examine the roles of both structure and agency through the medium of examining actors' experiences is underlined by Long's contention that actors both shape and are shaped by social structures in all their forms. Actor-oriented approaches such as Long's which are founded on constructionist views of social interaction understand the connection between actors and structures as a reciprocal process (Kontinen, 2004). In some cases, as Burawoy (1985) points out, this means that in constructing their own life-worlds, actors become the architects of their own subordination. To view the actions of individuals in isolation would be to obscure the power relations, strategies and limitations which form the basis for understanding the ways in which people interact with the institutions which shape their lives. As we shall

see, the strategies and limitations experienced by health workers become central to understanding the functioning of the maternal health systems in the areas in which I worked.

Examining the contingencies of practice, then, has become the work of actor-oriented theorists who seek to understand the experiences of development actors, and also the successes and problems associated with development interventions that cannot be explained purely in the context of policy analysis. In the case of community health interventions, such contingencies are key to understanding both the potential and the limitations of community maternal health systems, where the activities of individual local health workers have a profound effect on maternal outcomes. In addition to the acknowledgement of the need to examine the nuances of the actions and understandings of practitioners, it is also well established that development interventions are in turn not played out among relatively homogenous communities. Project implementation is always mediated through pre-existing relations of power, local interests and understandings, and attempts to subvert or disguise these interests is the subject of several ethnographies which aim to highlight the importance of understanding local processes to project outcomes (Quarles Von-Ufford, 1993; Gasper, 2000).

As we shall see in the case of health workers in the different villages in which I conducted my fieldwork, local histories, politics, economic relations, the way in which the role of health care provider is understood and the power relations which emerged from these factors had a profound influence on the capabilities of health workers and the understandings which informed their provision of maternal health care services. It is therefore necessary to develop an aesthetic device which allows us to view the connectivities between everyday social practice, power relations and fields of struggle, information networks, and the ontologies which underpin actors' coping strategies.

The network as a tool of analysis

In their efforts to mould such a device, theorists studying a broad range of phenomena including kinship lineages, political affiliations, mathematical systems and even humanitarian disasters have turned to the network form as a means to grasp the complexity inherent in human and non-human interactions (Mosko, 2005). Since the

1950s, network theories have been developed in a number of fields, producing a rich but complex body of literature which addresses the character of social relationships, and the new connectivities experienced through the advent of the information age. Simply defined, networks are ‘structures that link individuals or organisations who share a common interest on a specific issue or general set of values’ (Perkin and Court, 2005:v). Yet, as with many other social forms as tools for analysis, how one identifies, understands and applies the network as an analytical tool is contested in many different fields, from sociology and anthropology, to mathematics and cybernetics. In synthesising lessons from network theories, those of us seeking to apply the concept in the field of development studies must ask how networks can help us view the production of knowledge in contexts of poverty and inequality, and how they help or hinder positive social change by acting as conduits of power. I hope that by putting this knowledge into practice in the context of maternal health care I might suggest an approach which researchers from multiple disciplinary backgrounds can take forward in their task of addressing the state of women’s health care.

Networks have begun to emerge a key tool for analysis both in the academic study of development processes, and in the development industry. Most recently, contributions have been made which highlight the importance of understanding the role of networks in constructing effective health care organisations, and in mediating the relationship between policy and practice (Olivier de Sardan, 2004). In the latter case, much research has emerged recently on the subject of utilising networks in order to bypass formal barriers to consensus and improve the pro-poor impact of a policy (Bebbinton and Carrol, 2000). In addition to the academic progress, networks are created and harnessed by all from large international development organisations as a means to further consultation and accountability, to grassroots organisations looking for a platform from which they might connect with larger international discourses. In my application of networks as a theoretical tool I am guided by the particular conditions in which health workers enact their roles in West Africa, but it is first necessary to engage with ‘the network’ as it is understood more broadly by theorists who have drawn on this concept.

The emergence of the network as a theoretical form

Social Network Analysis was first proposed by Barnes in 1954, in acknowledgement of the fact that with new forms of information and institutional interactions, a theory was required which accounted for the complexity of the actions and relationships which ensue. Networks can help to demonstrate how linkages of community, friendship, and interaction between colleagues can become conduits for the flow of information. Developing appropriate language with which to talk about such complexities became a key task of social theorists, and in 1966 anthropologist Ronnie Frankenberg wrote that the network analogy constituted 'the first major advance in the language of sociology since *role*' (1966:242, quoted in Mitchell, 1969:4). Theoretical distinctions began to emerge between the network as a specific set of persons and relationships, as used, for example, by Radcliffe-Brown (1952) who employed the analogy to describe a social structure, and the network as an analytical tool.

The task of developing the latter was taken up in particular by Mitchell (1969, 1973) who argued that examination of social relationships through the lens of the network required an investigation of the *properties* of the interconnections inherent in the network form, an observation which led the way for analysing the nature of different complex relationships whilst connecting them with outside influences which shaped their behaviour:

The interest in these studies focuses not on the attributes of the people in the network but rather on the characteristics of the linkages in their relationship to one another, as a means of explaining the behaviour of the people involved in them.
(1969:4)

Network theories have emerged at various points since in multiple guises, but all have in common the desire to provide a way for analysts to talk about a particular social form whilst simultaneously acknowledging the heterogeneity of the relationships which inhere in that form. Some have suggested that we should focus not on actors or events, but the information that is transported by these agents (Bateson and Bateson, 1987). The notion that the kinds of relationships and practices which exist between entities, be they persons or things, is ontologically more significant than entities themselves has expanded from its philosophical roots into the fields of social and information sciences. This understanding suggests that we are connected with

persons, ideas, and institutions all over the world which under normal circumstances we would consider to have no bearing on our lives (Wildman, 2006). One of the most pressing questions which each discipline has sought to address in its own way is that of the substance and character of these relationships, and developing theoretical approaches which aid in addressing this aspect of inquiry.

In the 80s and 90s, Actor Network theorists provided a new model of the network which focused on the materiality of the relationships it has the potential to explore. The Actor Network is defined by the spread of modern informational practices, and constitutes a series of relationships between entities of all kinds, including humans and non-humans such as policy documents, computers and medical equipment. Networks of practice are constituted through daily interactions between these elements. These relationships are regenerated through the actions and interpretations of the actors involved; networks are upheld through 'translation', a process via which actors interpret certain ideas in order to generate the network and the consensus necessary to maintain it (Latour, 1996).

Latour's work invites us to challenge assumptions as to the a priori existence of sociological realms such as institutions. There are no 'sites' for sociological analysis per se, but actor-networks, constituted of 'connections, vehicles and attachments' (Latour, 2005:220). All actors, whether researchers or interlocutors, produce understandings and meanings on a daily basis which affect those of other actors at various points. As Mosse and Lewis (2005:13) have put it, 'actors offer scripts into which others can be recruited for a period'. For Mosse (2004), the utility of a networks approach is that it allows us to examine the way in which actors interact with one another, policy documents and organisational instructions, negotiating their understandings of these and constantly managing their working environments. He is particularly interested in the power of workers' understandings to affect change in a community, sometimes generating unexpected outcomes in development projects where the formal objectives become distorted through the practices and strategies pursued by actors at different organisational levels. For the purposes of my analysis, my concern then is not how health workers operate within a pre-given institution, but how projects and effects develop through their work of generating ideas, interests, and incorporating others into that process.

The element of a network approach which has endured as others have built on the theory is that it brings the actors and the power of their understandings and endeavours to affect change into perspective, whilst simultaneously offering us a concrete social form, the network, for the purposes of analysis. The aesthetics of this form are unique to the context at hand, for the character of the relationships that are produced are determined by the actors operating within the material conditions of their systems, such as the maternal health systems which are central to my research. Riles (2001) advocates a focus on the aesthetic properties of networks for what they can tell us about certain contexts, and provides the following definition of networks which I draw on in order to elucidate the characteristics of knowledge processes specific to the clinics in which I worked:

...a set of institutions, knowledge practices, and artefacts thereof that internally generate the effects of their own reality by reflecting on themselves. (2001:3)

Riles's view of the network form suggests that it might be utilised to view practices which are produced as a result of actors operating within a particular set of circumstances, an observation which may help to circumvent a central problematic of the network tool, namely that its seemingly infinite nature prevents theorists from adequately grasping the subject at hand. This is an issue to which I return shortly in my discussion of the potential problems posed by adopting a networks approach.

Networks, gender and power

The network is a useful tool for examining the way in which field level workers can affect change through dynamic interactions in their communities, and provides a means through which to observe the power processes inherent in network relations as they play out in particular contexts. The acknowledgement that workers have the capacity to reorganise network relationships opens up the possibility of the redistribution of power in ways which undermine dominant discourses. In *The Network Society*, Manuel Castells (2004 a) notes that new linkages are made possible by technologies such as the internet which collapse the distance between various localities, and weaken the control of dominant organisations over the organisation of daily life. Where communication technologies are not readily available, delays in the flow of information and instruction mean that the capacity of networks to reproduce

is limited, and hierarchical forms of organisations such as governments, religious organisations and bureaucracies maintain a key role in determining the structures which shape society.⁴

Although Castells's focus is primarily the scale and strength of connectivities generated by widespread use of communications technologies, his observations regarding the power processes which influence the generation and cessation of network activities also bring an important perspective to bear on communities in which information technology is not a principle means of organisation. These observations add a crucial dimension to the notion of the network as an analytical tool, especially given that discussion of the exercise of power inherent in network processes, particularly with regard to the marginalised and subaltern, has often been found to be lacking (Star, 1991). Castells wrote that:

Power does not reside in institutions, not even the state or large corporations. It is located in the networks that structure society...Power is exercised by specific configurations of networks that express dominant interests and values, but whose actors and forms can change... This is why to counter networks of power and their connections, alternative networks need to be introduced: networks that disrupt certain connections and establish new ones. (2004 b:224)

Social change, whether positive or negative, lies in the ability to create and cut networks. This is an important observation, bringing the network form into view not only as a means via which to understand relationships in the information age, but also as a means to view the dynamics of the power processes inherent in network relations.

In examining the activities and strategies of health workers, I am interested in their efforts to use networks as a conduit for information, and the relationships with their colleagues, patients and communities that develop or fail to develop as a result of their activities. In so doing, I am asking questions about power. Discovering what networking activities can tell us about relations of power is central to examining the efforts of health workers to improve the health of women in their communities. How

⁴ Castells's claims are controversial, not least because he is reluctant to define the network as a theoretical tool beyond acknowledging that the form constitutes a 'set of interconnected nodes'. This is in part due to his belief that theory should be communicated by analysing practice, leaving in this instance the particulars of the network form and processes open in order to maintain the flexibility of the concept (Stalder, 2006).

do health workers disseminate information about maternal health care, and how do they use networks to challenge negative attitudes towards reproductive health care and their clinics? Why do some networks achieve these aims, and why do others fail? In both contexts in which my fieldwork was carried out, women's experience of health and health workers' experience of health care provision are both shaped by deep inequalities, whereby the opportunities available to them are often severely limited by entrenched social norms which undermine women's control over their lives and bodies.

Applying a gender lens to a networks approach allows an explicit analysis of the ways in which the strategies of health workers both challenge, and are limited by, gendered relations of power in their communities. As Law (1992), a key proponent in the work of revising actor network theory, has said:

The task of sociology is to characterise these networks in their heterogeneity, and explore how it is that they come to be patterned to generate effects like organisations, inequality and power. (1992:3)

Examining the strategies of the actors with whom I worked has offered some hope as to the potential of health workers to act beyond the remit required by their health services, and find innovative ways to further the health and opportunities of women in their communities. As Castells has said, 'network morphology is also a source of dramatic reorganisation of power relations' (1996:471). In her work on global women's networks, Rai (2005) notes that while the agency of subaltern actors is rarely acknowledged, subaltern networks can become a significant tool with which to challenge dominant epistemological flows of power. She argues that examining the stories of the marginalised allows us to view "moments of rebellion" through which subaltern actors generate their life-worlds (Das, 1989:312, cited in Rai, 2005:125). Throughout my fieldwork, these moments emerged as key artefacts through which health workers attempted to challenge dominant knowledges and improve the health of women.

Potential problems of a networks approach

At first glance it may appear that opening up the theoretical field to include not only everyday practices, but connections between ideologies and conversations which

occur locally, nationally and internationally is too broad a stroke as to be useful. There is little doubt that the popularity of the network as a tool for social analysis has endured in large part on the basis that analysis might not be constrained by more traditional methods such as those which are limited to examining kinship structures or formal organisations, without offering a means of viewing the multiple forms of relationships which operate through and beyond these arenas. The network form is a powerful imaginary tool which has given rise to numerous visions of its capabilities, with some conceptualising it as a never-ending, fully self-replicating phenomenon which has the power to stretch the boundaries of time and space (Poster 1990:2). Prominent network theorists Lipnack and Stamps's early foray into networks analysis led them to characterise the network as:

the institution of our time. An open system, a dissipative structure so richly coherent that it is in constant flux, poised for reordering, capable of endless transformation. (1982:246)

In the same vein, Deleuze and Guattari (1987) employ many metaphors with which to conceptualise the infinite nature of social interactions, the rhizome being a particularly enduring image, along with notions of 'nomadism', and 'deterritorialisation' which imply boundless expansion. As Katherine Hayles aptly observes, 'Deleuze and Guattari develop a new vocabulary in which movement occurs without regard for the integrity of the skin' (2001:153). The language which many academics, development practitioners and organisations use to conceptualise network activities reflects this fantasy of a form that is all-encompassing, allowing access to all persons, things and phenomena, and therein we find both the power and limitations of the approach.

If the network form appears to be boundless, allowing endless connections to reproduce themselves in different contexts, analysis becomes abstruse, and even meaningless. Use of the network form has been considered illegitimate by some due to the chaotic and informal nature of the data (Scott, 1991). From the outset, theorists working with the analogy of the network have warned of its potential to obscure rather than illuminate social relationships, with Reader (1964) commenting that "the notion of network subsumes, and therefore obscures, several different aspects of social relationships such as connectedness, intensity, and status, and role" (1964:22, cited in Mitchell, 1969:2).

Yet as much as the network form has appeared to be all-encompassing, it has also suffered from being construed as narrow and homogenising, denoting a single topographical path along which meaning is produced. Such is the trap in which theorists attempting to grapple with complexity have naturalised and homogenised the character of the network form. At its most basic level, the network is a semiotic tool intended to illuminate complex relationships through distant social contexts, but its utility is often limited by the logic of space and spaciality to which networks are thought to adhere. As John Law points out, the notion of the network is itself a form that ‘imposes strong restrictions on the conditions of topographical possibility’ (1999:7).

Building a theoretical approach to analysing maternal health care

Finding a means to keep the network tool working for us rather than against has become the work of many theorists who continue to work with complexity as a means to examine social interactions and their connections to institutions and ideologies operating in diverse locations. As Marilyn Strathern writes in her work on the network as analytical narrative, ‘analysis, like interpretation, must have a point; it must be enacted as a stopping place’ (1996:523). It is necessary, then, to undertake a network analysis which acknowledges the heterogeneity of social relationships and the artefacts thereof, whilst not obscuring the system which is the subject of analytical interest. This, I take it, is the project of maintaining the ‘integrity of the skin’ to which Hayles (2001) refers.

This project has been taken up in the field of development studies, where developing methods for working with complexity has become the priority of theorists as well as development organisations seeking to meet defined goals, or view particular systems. Working with the complexities inherent in development processes may suggest the means to improve community-based interventions, develop more sophisticated project monitoring and implementation, generate ways to establish networks of cooperation between agencies, and provide a fertile context in which academic researchers might hone their interpretative approaches (Mosse, 1998). Each context in which development researchers and practitioners operate generates its own distinct patterns of networking activities, power and relationships, which tell a story about

that context, the systemic possibilities and constraints, and the understandings of the people whose life-worlds have become the entry point for our analysis. As Stalder (2006:177) observes, it is the generation of distinct patterns of interaction that gives networks their identity.

Throughout my fieldwork, observing the workings of maternal health services in rural communities brought the patterns generated by the provision and practice of maternal health care into view. As we have seen, the network form as a tool for analysis is evolving through a variety of different academic and practice-oriented endeavours, its genealogy taking on the guise of the form itself. Despite this expansion and many transformations, it remains for many working in the field of development and anthropology a means to address analytical phenomena which otherwise escape existing methods of understanding and description. The phenomena addressed by my own research require an approach which acknowledges the distinct character of the relationships generated by the provision of maternal health care, and can bring that into view alongside the wider systemic and material conditions in which maternal health care is organised.

I aim to demonstrate that maternal health care is unique in the particular kinds of strategies and network relationships that it creates. The health care workers I interviewed made relationships with women, their children, husbands, community social, political, educational and religious leaders, drawing them into their networks at the point at which it furthered their aims of improving maternal health care outcomes. The strategies they developed reflected their own particular understandings of maternal health care requirements, their understandings of community social and political relationships, and both the opportunities and limitations presented by the health care systems of which they are a part.

Examining networks is an attractive approach to understanding the flow of health care information which resonates deeply with the characteristics of the community-clinic relationships that I was able to observe. Yet there remains limited understanding of how networks operate in the provision of community health care, and even weaker discussion as to how they might be harnessed in order to facilitate progress on reducing the maternal mortality rate. As Rai (2005) points out, the popularity of the network concept in international organisations means that much of the literature

exploring the potential of networks frames networking processes narrowly within the context of powerful development institutions, and often focuses on the economic benefits of the 'knowledge industry'. What is now required is a different understanding of networking activities which reflects the agency of subaltern actors as they grapple not just with institutional and national boundaries, but boundaries of power which operate within their communities.

The efficacy of taking a networks approach to examine community health care relationships has been demonstrated in particular by Castle's (2011) work on the relationship between women's social networks and contraceptive uptake in Mali, and Cattell's (2001) investigation of community health information-sharing in East London housing estates. Castle found that in villages where contraceptive uptake was low, close networks of women served to reinforce negative messages and misinformation about contraception, including the very prevalent view in Mali that using contraception will render women infertile. In Castle's study, networks were mapped by asking women to identify who in the villages they relied on regularly for advice or help such as childcare, and who they spoke to about contraception. Outreach workers who were interviewed said that when they were unable to change the consensus views on use of contraception, they targeted 'intermediaries' such as relatives, or local midwives, and petitioned them to help persuade people to change their views. In one case, a male health care worker used his own personal networks in order to provide information about contraception, by asking his second wife to act as an intermediary in the village. This study demonstrates not only the insights that a networks approach can provide, but also the potential of harnessing networks to improve uptake of health care services.

Cattell (2001) has also examined the role of informal social networks in community health care, linking dense community networks to the sharing of vital health care information. Her work on social networks based around housing estates demonstrates that in areas where there were opportunities for regular interaction or formal networking, people were more likely to share health care information and seek help from medical professionals where necessary. She also found that in some cases, small, tight knit networks were a barrier to people joining wider networks and gaining access to more information and advice. Where people profess to 'look after their own', external services such as educational visits or women's projects which offered the

opportunity to gain information and advice on health care were not well attended. This work is particularly significant for what it tells us about the aesthetics of different kinds of health care networks, demonstrating that the size and density of social networks can be beneficial or detrimental to health care information sharing depending on the context in which they are formed. This insight proves particularly useful when examining evidence from communities of different sizes experiencing different demographic trends in the districts in which I conducted my fieldwork.

I now outline several theoretical themes which have emerged from my own research, and which may be viewed as artefacts of the conditions in which maternal health care was provisioned by the health workers with whom I worked.

Theoretical themes: formal and informal networks, strategies and ‘failure’

In approaching the networking activities of health workers in both Mali and Ghana, I began to consider the different incarnations of the health care relationships which they enacted on a daily basis. The entry point for analysing the basis of these relationships in Ghana was the formal mandate of the CHPS system which required health workers to generate linkages with their communities through regular events and visitations. In contrast, the community relationships generated in Mali occurred for the most part as a result of the informal networking activities of health workers who took it upon themselves to connect with members of their communities in order to promote community clinic services, and offer advice regarding maternal and reproductive health care. The challenge as to how to view these health care networks side by side was twofold. The first point of contention is a methodological one which is already well-established in the field of development; analysing informal networks has historically been extremely difficult due to their dynamic and personal nature. Gaining access, identifying key actors and maintaining an ethnographic view of a sometimes transient and nebulous form have all limited investigations of this nature. The second issue is one of analytical form – what characterises formal and informal networks, and at what points do they intersect?

Whilst studies of subaltern networks have tended to examine formal networks (cf. Rai, 2005), in analysing the networking activities of subaltern actors, it is also

necessary to examine the informal networks through which these actors share their understandings and experiences. Perkin and Court's (2005) recent work for the Overseas Development Agency on utilising networks highlighted the need for further understanding of the role of informal networks in development processes. They argue that work on the role of social capital in particular has underlined the need for such understanding, demonstrating that the advancement and maintenance of personal relationships can have a significant impact on formal organisations and activities (Coleman, 1990, Putnam 1993).

Epistemic communities consisting of persons with relevant knowledge and shared interests also play an informal but important role in challenging problematic policies and organisations, creating the potential to introduce new priorities (Haas, 1991). In their work on policy implementation, Perkin and Court conclude that informal networks have the potential to facilitate communication in both horizontal and vertical dimensions, inspire creativity due to the informal and interactive nature of communication amongst actors, and create a space for like-minded persons to rally around a common issue. Yet whilst informal linkages seem to have a significant impact on development outcomes, there is limited literature available on understanding the way in which dynamic informal communications might operate in practice to affect positive social change.

Borzel (1997) notes that informal linkages based on communication and trust help to resolve issues by connecting different organisations or persons independently of the formal relationships established between them. Identifying these processes is particularly important in contexts such as the rural Malian clinics in which I was working where actors have little or no formal linkages with which to share their ideas. By examining networking activities from the perspectives of health workers, I am able to bring these actors into view as the 'knowledge-makers' in the maternal health care systems in which they operate, who are working to challenge dominant flows of epistemological power within their communities.

The central benefit to my research of examining informal networks is that it emphasises the importance of understanding the different meanings and significances of routine practices to the actors involved. I hope to demonstrate that health care workers produce and negotiate practices on a daily basis as a consequence of the

health care systems in which they are operating. Long (2001) has referred to this process in development as the 'social life' of projects, and argues that it is necessary to produce ethnographic accounts which examine the lived experiences of the actors involved. In the case of the practice of maternal health care, I examine the daily activities and understandings of health workers in order to establish the strategies that they develop in order to further the benefits of maternal and reproductive health care in their communities.

Analysing formal and informal networks

Now that the potential benefits of including an analysis of informal networking practices has been established, I turn to the second issue, that of how to view informal and formal health care network processes in Mali and Ghana vis-à-vis one another, as an artefact of the maternal health care systems in which they were produced. One of the most striking features of the analytical form which emerged from my fieldwork was the relationships between the formal and informal elements of health care networking activities, and the points at which they intersected. The networking activities of the health workers in the districts of each country in which I worked shared many similarities, although those carrying out these activities understood their own actions to take place in very different contexts. Health workers in Ghana primarily made sense of their relationships with their communities in relation to the CHPS programme which mandated their health care activities; those in Mali often understood their relationships to be a product of their own personal duties and connections rather than as a formal product of the health service of which they were a part.

A comparison of health workers in the two countries suggests that the formal and informal maternal health care networks enacted by health workers in each case are in fact different versions of a pattern which emerges through the provision of maternal health care in rural contexts in these countries. In each case the health workers were responding to the conditions in which maternal health care was provisioned, creating a pattern of formal and informal relationship interactions as they adapted to their own needs and the needs of community members. It is for this reason that examining these patterns as a means of analysis is helpful for telling us about the realities of maternal health care provision.

Although I initially understood the relationships formed by Malian and Ghanaian health workers in discrete terms of the formal and informal, in practice these relationships were blurred in both cases. It became clear that the analytically significant question is not one of identifying the formal and informal, but how these activities were understood by the health workers themselves as a response to the conditions in which they worked. Here we have a situation in which health care workers in Mali and Ghana define their health care relationships in multiple ways in terms of their formal roles as government health workers, or in terms of the personal roles and responsibilities as members of their communities. What is more, in the Ghanaian context a further analytical picture of networked relations is already present in the form of the CHPS mandate to generate health care relationships in communities. As Riles (2000) points out, in modern policy-making contexts it is necessary to distinguish between networking practices which we as anthropologists are identifying, and networking practices which are already present and formally acknowledged in the contexts in which we conduct our research.

The health workers with whom I worked in Ghana understood their activities to be a product of the CHPS requirement to make health care relationships, even though they often made informal decisions which often did not correspond to the requirements of the policy. Individual strategies and collaborations between small groups of health workers were commonplace, but were understood by them to take place in the context of formal requirements. Many of the health workers with whom I spoke analysed their own activities as a product of the CHPS system, particularly its limitations.

In Mali, the distinction between the formal and informal elements of health workers' activities in practice was also defined on a daily basis by health workers. It was not unusual for health workers to take part in informal networking health care activities which they acknowledged were not officially part of their government mandate, but which many nevertheless saw as central to their role. Others would say that any such activities were 'personal', and therefore had no place in their work day.

In both Mali and Ghana, the health care activities that took place inside and outside of the formal mandate were negotiated by health workers who had to operate through the opportunities and limitations inherent in the maternal health care contexts in

which they worked. In both countries those who could not meet formal requirements, or found the formal requirements lacking, would often initiate their own informal strategies with which to move forward with their task of providing maternal health care. The way in which these activities were defined by health workers was determined through the necessities of the particular context at hand.

Analysing the patterns which emerge from the practice of maternal health care in Mali and Ghana demonstrates that we are not just viewing two discrete contexts in which community health care relationships are informal in one case, and formalised in the other. Rather, in both cases health workers would often work formally and informally on a daily basis, responding to the challenges of providing maternal health care to their communities as they arose. In beginning analysis by looking at the patterns of health worker activities which emerge rather than starting with the health systems in which they operate, we are better able to view the elements which influence the realities of maternal health care provision. The sociologist Duncan Watts, who has written extensively on the use of networks in social analysis, has said that we should *'focus not on the stimulus itself but on the structure of the network the stimulus hits'* (2003:249, emphasis added).

The implications of this for theoretical analysis are highly significant, not least, as Stalder (2006) points out, because it advocates examining effects as an entry point for analysis, rather than the more traditional approach of starting with a 'cause' – be it a policy, a political or economic event – for the purposes of explaining the contexts at hand. According to Stalder, it is for this reason that a key tenet of complexity theory is that small causes may have large effects and vice versa (2006:174). Thus I move forward on the principle that in analysing the everyday understandings and activities of health workers rather than beginning by analysing the health services at hand directly, we might better see the particular issues which affect the provision of maternal health care.

Strategies and limitations: brokerage and network failure

In examining the contingencies of practice inherent in the everyday activities of health workers, a further theoretical theme began to emerge. In order to navigate the conditions in which they provided care to their communities, it was necessary for

health workers to strategize and improvise on a daily basis, generating a pattern of activity which reflected the conditions in which they operated. These strategies can be viewed as a product of the restrictions and opportunities encountered by health workers, and contribute to an environment in which new, unplanned health care relationships and approaches are developed. Understanding actors' strategies is a central tenet of actor-oriented approaches, not least because studying this element brings the broader factors such as the structural and personal opportunities and limitations which influence actors' decisions into view.

Bierschenk et al (2000) have used the term 'brokerage' to refer to the ways in which social actors operate as active participants in generating development realities, a term which has been taken up by Mosse and Lewis (2006) and others seeking to combine these insights with some drawn from the sociology of science. Expanding the notion of brokerage, Mosse and Lewis propose that Latour's concept of "translation" can help explain the processes via which development worlds are constructed on a daily basis through the strategies of actors who have a stake in them. They argue that those involved in development processes modify and negotiate their ideas and activities in order to avoid contradictory interests:

The ethnographic task is thus to show how, despite fragmentation and dissent, heterogeneous actors in development are constantly engaged in creating order through political acts of composition. (2006:14)

The health workers I observed would regularly engage in such 'acts of composition', putting their ideas and understandings together, and recruiting actors, whether they are their patients, patient's families, or community figures, into their plans. This strategy was particularly popular amongst health workers seeking to advocate clinic services in areas with low uptake of clinic services. In situations in which women's families were reluctant to allow them access to reproductive health services, the ability to draw on medical, social and cultural knowledge in order to advocate services in an appropriate way was a key means for health workers to translate information such that it would be understood favourably by members of their communities.

In addition to the strategies employed by health workers in order to connect with their communities, they would also broker arrangements between themselves in order to cope with the limitations of the health care context in which they worked. In

particular, ethnographic evidence drawn from clinics in Ghana suggested that health workers often felt it necessary to adjust their working practices in order to accommodate multiple factors, including community beliefs and attitudes, and systemic problems such as transport and staffing which it was not in their power to address directly. Many of these strategies gained momentum and became solidified through unofficial consensus between health workers, who brokered new arrangements in health care provision in order to cope with the demands of the contexts in which they worked.

Examining the patterns produced by the strategies which health workers engage to cope with the realities of the maternal health care contexts in which they operated sheds considerable light on the potential of community health workers to address the problems of rural maternal health care provision. However, my fieldwork also yielded circumstances under which health workers were unable or unwilling to broker positive community health care relationships, and these ‘failures’ are equally instructive as to what they tell us about the conditions under which maternal health care is provisioned.

Examining these cases indicate the challenges faced by health workers in creating and maintaining successful maternal health care networks, and demonstrate the conditions under which such networks fail to thrive. To return to Strathern’s (1996:523) work on the way in which networks might be ‘cut’, networks which are rendered contingent on people’s interactions have an ‘inherently fragile temporality’. Failure to maintain a network results in a breakdown, which is useful in itself for what it tells us about the conditions in which the network was created. Further, as Lee and Stenner point out, mapping social relations as a network is of little use unless we are aware that such networks are open to fundamental change, be it a ‘stop, a start, or a departure’ (2001:110). The coping strategies and limitations employed and experienced by health workers form a critical element of the network tool outlined here, giving a unique shape to the pattern formed by the activities of health workers providing maternal health care services in their communities.

I have made an argument for understanding rural maternal and reproductive health care systems through examining the activities and understandings of the health workers who provide maternal health care services in the communities in which they

reside. In approaching analysis from this perspective, it is important not to lose sight of the systemic factors including relations of power, economics and politics which influence the strategies employed by health workers in their daily activities. I have put forward a version of the network as a tool for examining community health care, as a means to illuminate the relationship between the activities, strategies and difficulties of health workers and the wider conditions under which they arise. I have also attempted to demonstrate that the network tool brings patterns of behaviour into view, patterns which my ethnographic analysis will show are unique to the provision of maternal and reproductive health care. In viewing maternal health care in this way, I argue that we might better understand the challenges that characterise the provision of maternal health care in rural Mali and Ghana.

Chapter 4: Research methodology

This research began as an independent PhD project undertaken in the Development Studies Department at the School of Oriental and African Studies. The broad focus of the project from the outset has been to investigate how the social elements of health care are integrated into the provision of clinical services in women's health care. From there the project has morphed in several ways, responding both to elements which came to the fore through additional study of the context of women's health care, and to the coup which demanded a change in location and organisational focus. Asking how social approaches designed to empower women were understood in the conceptualisation and practice of Malian health care, the project was originally intended to investigate the roles of NGO and government health care workers in incorporating empowerment initiatives into their daily clinical activities.

As the project developed during the MPhil, a focus on maternal health care emerged, after it became apparent that this area constitutes a very distinct area of women's health care in which understanding the interaction between clinical service provision and the social elements of health care provision is crucial. Whilst much progress has been made, maternal health remains one of the most pressing issues faced by the governments of Sub-Saharan Africa, international aid agencies and advocates of women's health and rights, who are now calling for initiatives designed to address the social side of maternal health care provision with a view to improving uptake of services. These developments suggested that examining the integration of social and clinical initiatives in the context of maternal health care would yield timely insights into the nature of maternal health care, and provide valuable information as to how such integration might best be performed to improve maternal outcomes.

Examining international approaches to maternal health care also raised issue of how initiatives designed to address women's health and rights have been conceptualised and implemented. My original focus was specifically on health worker engagements with empowerment approaches, but further research suggested that tensions between rights and empowerment initiatives and instrumental approaches are at the crux of the current problem of integrating the social and the clinical in maternal health care. How empowerment is understood by different international agencies and in different health

care contexts was a key factor, as was whether empowerment was part of the vocabulary of those with whom I was to work at all. It became clear that whilst NGOs spent much of their time contributing to nebulous discourses of empowerment, in contrast the government health service providers with whom I worked had little knowledge of the concept, and understood their activities in a very different way. For this reason, my empowerment focus broadened to an examination of social approaches, allowing me to ask not only how this element is integrated with clinical activities, but also how the way in which we understand the social component affects the efficacy of integrated health systems.

Organising fieldwork in Mali

The research in Mali was conducted with the approval of the head of the reproductive health section at the Ministry of Health, Dr Binta Keita, and a senior midwife at the ministry, Mme Hawa Diallo. I found that with the help of contacts including health researchers and local consultants I was able to meet very soon after my arrival with these key figures at the Ministry of Health, and secure their backing for the project without any significant changes being required. I had the opportunity to discuss the project at length with Dr Keita, and I presented her with a research outline and some sample interview questions translated into French for her approval. Her initial concern was that I might want to work with young mothers who would be unable to consent to the research without parental approval which would be difficult to obtain, and many of whom would be very vulnerable. I understood that she had assumed my research would follow a similar path to those of other studies on maternal health care undertaken in Mali, which had largely focused on mothers and health-seeking behaviour (cf. Etard et al, 1999; Gage, 2007,). Through my discussions with Dr Keita and Mme Diallo I established that I wished to investigate health worker perspectives and their impact on maternal health services, and gained approval for the research to go ahead.

After outlining the project parameters, it was decided that I should conduct the research in the Koulikoro region, and would be granted access to four government-run clinics located in the Cercle of Kati, a predominantly rural area with a population of 948,128 (Mali Census, 2009). The clinics in which I worked were Neguela, Dio Gare, Diago and Malibougou. The first three were located in rural areas, Diago and

Dio Gare serving 7 villages respectively and Neguela 16. The final clinic, Malibougou, was located in the town of Kati, a military town whose population of 114,983 was expanding rapidly.⁵ The clinics were selected on the basis that they all lay in the Kati Cercle, an administrative sub-division of the Koulikoro region, and provided the opportunity to examine both rural clinics and a larger one serving a growing population. Whilst I spent much time in Diago, Dio Gare and Malibougou, I spent little time in Neguela which lay further out in the region, and proved to be extremely difficult to travel to both in terms of distance and the condition of the roads.

Having obtained the approval of the minister for reproductive health, I was then referred to the regional health director for the Kati district in which the selected clinics were located. Obtaining the cooperation of the regional health director was crucial, as it was he who had the power to instruct his clinic staff to admit me for the purposes of research. Securing a meeting with him proved difficult, which was not unsurprising given that the regional director is extremely busy and regularly moves between several locations over fairly large distances. Once we had the opportunity to discuss my research, he presented me with a letter instructing the heads of the clinics to accommodate my visits. From there I began making regular visits to the clinics, interviewing health workers and observing their daily activities.

The Mali coup and its impact on the research design

For some time before the events of March 22nd, there had been growing concern in the south over the government's response to the Tuareg rebellion in the north, an uprising led by the National Movement for the Liberation of Azawad (MNLA) who sought to create an independent Islamic state in the north of Mali. The Malian army had suffered severe losses in the campaign against the MNLA, and in the months leading up to the coup protests had taken place in the capital over the lack of training and resources made available to the army. Despite the demonstrations, a coup attempt had not been foreseen by national or international spectators, particularly as a prime ministerial election was due to take place the very next month.

⁵ Demographic information obtained from the Mali Population and Housing Census 2009 (National Institute of Statistics (INSTAT) (Mali), 2009)

The capital was chaotic in the days that followed; shops and houses were looted and jubilant soldiers fired their weapons in the air, killing several civilians. Although I had been advised by the British ambassador to leave as soon as possible, it was several weeks before I or any of the researchers and NGO workers of my acquaintance were able to do so. Aside from contacting our anxious families and making preparations to leave, we were left with a considerable amount of time to reflect on our situation and the plight of the Malians with whom we had been working only a short time previously. The circumstances were an illustration par excellence of the fact that fieldwork can go awry unexpectedly, in ways that would challenge even the most seasoned researcher. No matter how prepared we are the field is complex and unpredictable, requiring us to exercise both the humility of a researcher approaching a subject from scratch, and the expertise of academics able to adapt their practice to the twists and turns with which they are confronted. As Bob Simpson writes, 'you don't do fieldwork, fieldwork does you' (2006:125).

Although we were unable to leave the house for some time, my housemates and I were visited by neighbourhood friends who were undeterred by the curfew and the general unrest, which gave me the opportunity to talk with them about their perceptions of the coup and their experiences of health care in Mali. When the streets became quieter in the following weeks, I made visits to a contact who had lived in Mali for much of her life, and collected oral histories about the communities in which I had been working. Whilst it was not possible to visit the clinics in which I had been working again, I was able to use the time between the putsch and my eventual departure to participate in conversations that informed my final thesis, and provided insights into local perceptions of the extraordinary events which were unfolding.

Whilst I was fortunately able to formulate an amended research plan which I was satisfied would adequately address my research questions, there were other challenges posed by the coup which did not offer such tangible solutions. One of the most pressing questions I had in the wake of these events was how would the provision of maternal and reproductive health services which I had been investigating be affected by the coup and political instability which followed. In the wake of the coup, many international donors withdrew aid to the country, a third of which would have been destined to support community health care. Later, as the chaos in national government left the country vulnerable, the MNLA moved south, taking towns,

displacing large numbers of people who fled to the capital and to the nearby Kati district where I had been working. The pressure on community health services was immense, and health workers whose salary payments were already erratic would have to cope with an increasing demand for their skills whilst the government which was responsible for paying their wages was in disarray. At the time I could only guess how the events of the coup were likely to affect the provision of community health services, but the suddenness with which the research came to an end was difficult to process. Pollard (2009) has noted that the common feelings of guilt and loss felt by PhD researchers leaving the field are not often talked about. These feelings are compounded under circumstances such as mine in which I was unable to say goodbye to my interlocutors, to properly thank them, or to fulfil trips and visits which we had planned.

When the sanctions were lifted and I was able to return to the UK, I was faced with the task of evaluating the data I had collected and considering how the research project might be reformulated to accommodate the fact that I had not been able to complete my proposed research with the NGO in Mali. The fieldwork I had done in the time I was in Mali had almost exclusively focused on government health workers and the clinics in which they worked, and I had been able to collect a significant amount of data during the time that I was there. With the support of my supervisors, I therefore determined that rather than seeking to compare the experiences of government health workers with NGO workers, it would be fruitful to compare the data I had collected in Mali with the experiences of government health workers in another West African country. It was important that the new research context would put my existing data on the provision of maternal health care into a useful perspective, and aid in my investigation of the integration of social and clinical health care initiatives and maternal health care. Mali has one of the highest maternal mortality rates in the world, and I now wanted to work in a country which had made further progress in this area and in the area of integrating social initiatives into community health care.

Incorporating a comparative perspective: extending the analysis to Ghana

I was invited by contacts at The University of Ghana to complete my project in Ghana with their support, a development which had a profound and positive impact on my research. Although progress in reducing maternal mortality has been slow, Ghana's mortality rate is less than half that of Mali, and the health service had recently begun to implement a scheme intended to fully integrate government health workers into the communities in which they worked. Whereas the majority of the social side of maternal health care in Mali had been performed informally by health workers, here was an opportunity to view the effects of a programme designed to formalise the social side of health care in rural communities similar to those in which I worked in Mali.

With the support of the School of Public Health at The University of Ghana, I focused the second half of my research on the Community-based health planning and services initiative which was being rolled out in the Shai-Osudoku district. The project was designed to bolster the social relationships between health workers and communities, in the hope that this would encourage uptake of services and allow health workers to monitor individuals in their communities. To that end, health workers participating in the programme were to live and work in local clinics, conduct regular visits to the houses of community members, and network with community leaders. It was through examining the Ghanaian approach to community health care that I was able to view a health system which formalised social elements of care and combined them with clinical provision, and the implications of this for maternal and reproductive health care.

Although the focus of this research project had always been on the process of integrating clinical and non-clinical approaches to health care, the addition of the CHPS project in Ghana to my field of research served to focus my investigation, and raised key questions as to what happens during attempts to formalise social initiatives in the delivery of community health services. From here, I was able to assess the informal social strategies of health workers in Mali in conjunction with the activities of Ghanaian health workers who were mandated to perform social initiatives in

addition to their clinical duties, and draw wider insights into the potential of integrated health systems to improve maternal health care.

Unlike the formal beginnings I had in Mali through meetings with senior government health figures, my introduction to research in Ghana was a more lateral process, and was predicated on local professional relationships rather than on the authority of a minister. Having begun this time with contacts at the University, with their support I was referred directly to the district health administrator of Shai-Osudoku with whom they had a professional relationship in order to make my case for completing my research study. Based at the district hospital in Shai-Osudoku, the district administrator was amenable to my request, and agreed to allow me full access to clinics in the area, with the proviso that the School of Public Health write me a formal letter of endorsement. Whilst this in itself was easily obtained, this marked the beginning of a pattern in which each health care official involved in running the community health programme in the required a letter of permission regarding my research from their immediate superiors. After obtaining several different letters granting me access, I was permitted to begin visiting clinics and the health workers who staffed them.

Lacking the ministerial authority I had in Mali, the research was in some ways less formal, but the process required to gain access at the district level was my first introduction to the bureaucracy which characterised the administration of the community health programme. It also afforded a valuable opportunity to connect with several of the personnel who were involved in running the programme, including the CHPS coordinator who told me much about how the programme operates in the district, and crucially the head nurse who is the point of contact for community health workers in the area. It was she who informed me about the clinics in the area, and introduced me to the staff of the clinics chosen for my study.

As in Mali, I selected four areas in the district in which to conduct my research: Ayikuma, Agomeda, Ayenya, and Doryumu. They all served small, rural populations and accommodated a number of surrounding villages. Ayikuma and Agomeda were fully functional CHPS compounds, staffed with a midwife, an enrolled nurse, and several CHOs. Ayenya was also a CHPS compound run by CHOs, but was no longer staffed by a midwife. The clinic differed from the others in the area in that it was built

in conjunction with a local school with funds from Orphan Aid Africa. Doryumu was a fledgling member of the CHPS programme, with three CHOs but no clinic compound as yet. There the CHOs lived in their own individual accommodations, where they kept supplies and saw patients. Doryumu was known as a CHPS zone, where health workers were based in the community and engaged in the project of connecting with community members and laying the groundwork for the eventual building of a community clinic. As with other CHPS areas, they were responsible for a number of outlying villages in the area.

Data collection and analysis

During my time in Mali I stayed in the west of Bamako, and made frequent journeys from there to my selected clinics in the Kati district. In Ghana I stayed for the most part in student accommodation on the university campus, and travelled from there to the clinics in Shai-Osudoku on a regular basis. In both locations, once the research project had been approved I spent the majority of time in the clinics selected for the study. In Ghana my time was spent either in clinics, or traveling on foot with health workers as they visited the allotted villages in their area to conduct home visits and child welfare clinics.

For the purposes of my research I employed several qualitative research methods which I selected on the basis that they would best allow me to view health workers' understandings and strategies, and the impact of these on the provision of maternal and reproductive health care:

- Participant observation of health service delivery both inside and outside clinics
- Semi-structured interviews with health workers, health care volunteers and health administrators
- Focus groups with community health workers
- Supplementary oral histories of women's experience of maternal health care and regional political histories

In both Mali and Ghana I undertook extensive participant observation in order to appreciate the nature of different health workers' daily activities, and the strategies

they employed when interacting with patients and members of their communities. Participant observation was a crucial component of my actor-oriented focus, which required that I familiarise myself with the actions, understandings and environments of those with whom I worked. On each occasion I took detailed notes of my observations, many of which informed the interviews with health workers which were subsequently undertaken. The activities observed during participant observation in each research location are outlined below.

Fig 2: Participant Observation Undertaken in Mali in 2012

- 2 Post-partum clinic care
- 1 Child vaccination day
- 12 Pre-natal consultations
- Multiple clinic visits observing day to day activities

Fig 3: Participant Observation Undertaken in Ghana in 2013

- 4 Child welfare clinics
- 1 family planning consultation
- 1 postnatal consultation
- 16 Home visits
- 1 School Visit
- Multiple clinic visits observing day to day activities

In addition to the participant observation detailed above, I also conducted interviews with a number of different government health workers, health volunteers and health administrators in both locations. The health system of each country involved a number of actors working at the district and community level, with varying responsibilities and approaches. I interviewed a range of actors involved directly and indirectly in the provision of maternal and reproductive health care in order to get a detailed picture of how each community health system as a whole worked for women. Interviewing a variety of health workers with different roles also allowed me the opportunity to explore recurrent themes, and to check whether certain behaviour and understandings were common or unique to individuals or roles.

The majority of the interviews took place on an individual basis, although I also conducted some focus groups which gave me the opportunity to observe health workers discuss emergent key themes with their colleagues. This technique had the advantages of highlighting the issues which most commonly troubled health workers, and listening to their colleagues discuss these elements encouraged others to express their own views. This was a particularly important factor when discussing the role of women in the respective societies, health workers' views of the advantages and limitations of their own roles, and their own personal experiences living and working in their communities. Focus groups also served to increase health worker confidence in their own participation, emboldening many of them to provide me with feedback on my interpretations and to ask me personal questions which helped to build more equitable research relationships. The roles of the respondents interviewed in Mali and Ghana are presented below. Staff based at community clinics and community health zones were interviewed on multiple occasions, and the majority of interviews were recorded using a digital recorder.

Fig 4: Interviews and focus groups undertaken in Mali in 2012

Semi-Structured Interviews

- 8 Matrones
- 4 Sage-Femmes
- 2 Infirmières
- 6 Médecin-chefs and auxiliary managers
- 1 Obstetrician
- 2 Community Relais
- Senior Midwife, Ministry of Health
- Deputy Chief, CARE/Keneya Ciwara Project

Focus Groups

- Mixed group including Sage-Femme, Obstetrician, and Matrones
- 3 Matrones

In addition to participant observation and semi-structured interviews, I collected three oral histories in Mali, each of which served to highlight different themes which contributed to my analysis. The first was with a family relating their experiences of the health care system during through pregnancy and a complicated delivery. The second

was with a young woman relating her experiences of helping a young relative who had attempted to abort her pregnancy. The third was with a contact with a wealth of knowledge about the history and local politics of the district in which my research was conducted.

Fig 5: Interviews and focus groups undertaken in Ghana in 2013

Semi Structured Interviews

- 8 CHOs
- 1 Senior Community Health Nurse
- 2 Enrolled Nurses
- 2 Senior Staff Midwives
- 2 Community Health Volunteers
- 1 Public Health Nurse
- District Health Administrator
- District CHPS Coordinator
- District Director of Nursing Services
- School of Public Health Administrators

Focus Groups

- Mixed group including midwife and CHOs
- Mixed groups including CHOs, senior community health nurse and Enrolled Nurse
- Groups of CHOs

The advantages of undertaking qualitative research for those hoping to illuminate intricate social practices are well documented. The methods outlined above were selected because of their potential to explore the activities and perceptions of the health workers at the centre of this research, in addition to the opportunities they provided for observing the relationship between broader social structures and individual behaviour. For this reason, participant observation constituted the foundation on which this research was conducted, and was supplemented with the semi-structured interviews and focus groups which were designed to aid in drawing out health worker understandings.

Participant observation requires the researcher to immerse themselves in the social setting for extended periods, allowing them to familiarise themselves with the social

practices, understandings and patterns in behaviour which generate the social context at hand. Where it is successful, immersion in this environment allows researchers to witness and engage in conversations and practices which help further their understanding of the social phenomena at work. This level of engagement was crucial to my work which sought to illuminate the complexities of health worker understandings and their capacity to strategically alter health outcomes for women.

In order to view health workers' daily decision making processes and the constraints under which they were operating, an approach was necessary which allowed me to view these processes on an on-going basis, and at different points in the day, week and month. Working in contexts in which health workers undertook both scheduled and unscheduled activities, it was necessary to observe regularly in order ensure that crucial processes and events were not missed. As Hammersley and Atkinson (1995) point out, timings must be considered as important a factor as the choice of research participants, as it is necessary to ensure that people and events are observed at different times of the day or week in order to minimise the risk of drawing erroneous conclusions about the factors which influence behaviour.

The more time researchers spend participating in the lives of their interlocutors, the higher the level of congruence between their observations and the theoretical approaches to the context that they develop. In conducting regular and prolonged observation of health workers as they took part in multiple activities in different contexts and following up my observations with interviews and group discussions I was confident that the theoretical approach I constructed would reflect the realities of the health workers with whom I was working. This was a critical factor not least because in conducting a small-scale, ethnographic study, my findings would not necessarily lend themselves to generalisations across other social settings. As such, a considerable degree of participant observation was required in order to ensure that the patterns of behaviour I discerned were indeed present and relevant amongst different health workers in the multiple contexts in which they worked.

A principal means to ensure that research findings correspond to the experiences and understandings of interlocutors is to keep them informed of the research process and results, thereby giving them an opportunity to corroborate or challenge findings. Participant observation, semi-structured interviewing and focus groups all provide

excellent opportunities not only to gather data, but also to share it with research participants, and ask for their views. During interviews and conversations which took place as I was observing or assisting health workers, I was able to discuss the patterns in behaviour I had observed and ask for the opinion of those with whom I was working. This yielded many useful insights, both regarding the observations I had made and the conceptual approach I had employed to interpret them. For example, as I will discuss in more detail later, several interviews and conversations with health workers in Mali suggested that whilst my observations about the constraints experienced by women accessing health services were accurate, my assumptions about the framework in which these constraints were understood by health workers was not.

A further advantage of participant observation is that it opens up possibilities for the researcher to forge good relationships with their interlocutors. Regularly observing and participating in the everyday lives of those with whom they are working can often facilitate opportunities for discussion and understanding which inform interviews and group discussions. For the purposes of this research project, trust and the ability to have productive conversations about health workers' thoughts and decision making processes was paramount. Establishing these relationships proved to be essential, not only furthering the access I had and the depth of the information I was able to obtain, but also forming a solid base from which I could discuss my observations with the health workers with whom I worked.

Although I was confident that the qualitative methods which formed the basis of this study would be crucial to illuminating key aspects of health worker behaviour and understandings, it was also necessary to address, and where possible plan for, the potential problems associated with the methods selected. One of the main areas of concern was that when observing and conducting interviews, researchers have the power to decide what is important both through what they choose to observe and ask, and what they choose to highlight. Fabian (1983:151-2) observes the power of the researcher to authorise dominant discourses, arguing that 'as long as ethnographic knowledge is primarily conceived as observation and/or representation... it is likely to persist in denying coevalness to its Other.' For this reason, and because the context of women's health is one in which the voices of many actors have historically been excluded, it was particularly important for me to acknowledge the dynamic nature of the contexts and identities in which I was working. During the research process I

attempted to use the opportunities afforded by participant observation and the interview process to discuss the views and concerns of health workers, which both enriched my understanding of the dynamics at work, and provided space in which they could be heard, space which was markedly absent in the systems in which they worked.

Providing such opportunities also went some way towards addressing a principal problem associated with qualitative research as a whole, namely that those being observed and interviewed may alter their responses as a result of the presence of the researcher. In many cases, research participants are likely to be affected by the characteristics of the researcher such as age and gender, and in addition may adjust their responses based on what they believe they should say or do. On the whole I found my age and gender to be an advantage when investigating maternal health systems in this context, an observation which I discuss further below. The issue of health workers' perceptions of what they perceived to be 'correct' responses was more complicated, but I found that I was able to address this through a sustained and reciprocal approach to the research.

During my time in the field I spent a considerable amount of time with health workers and provided them with many opportunities to discuss their views, a strategy which went some way towards mitigating their initial concerns about revealing disparities between their official mandates and the realities of their activities. The use of focus groups under such circumstances can be problematic, especially where participants are reluctant to reveal their personal views and experiences to colleagues. Whilst remaining aware of this issue, I learned that providing health workers with opportunities to discuss their experiences with one another created a focussed environment for peer exchange which they did not necessarily have in their daily lives. I was also willing to share my own experiences and opinions about the issues which concerned them, for example women's access to contraception, conversations which went some way towards establishing reciprocal relationships.

Finally, analysis of many of the issues reported by health workers suggested that further research in this area would benefit from a broader engagement with health system personnel. In particular this includes district health administrators and – especially in the case of Ghana – programme coordinators, who could help connect

the understandings of health workers to those of the officers responsible for administering the respective community health systems. Whilst beyond the scope of this study, further investigations could make use of participant observation, interviews and focus groups in order to establish the connections between those playing different roles in the management and delivery of community health services.

My experiences in the field typically supported my choice of methods, and I was interested to find that the issues which did arise, such as a lack of credibility due to the fact that I do not have children, could often be addressed through a willingness to participate both in activities and reciprocal dialogue with health workers. There were, of course, a number of different problems which arose during the course of my fieldwork, directly or indirectly associated with my choice of research methods. Some of these required adjustments to the research to be made in the field, and I return to these shortly in a discussion of field adjustments.

As a consequence of the research methods I had selected, I had collected a large amount of raw data at the end of my time in the field. Qualitative research by its nature produces large amounts of text in the form of field notes and interview transcripts which, whilst they provide a plethora of information, can be difficult to navigate due to the volume and intricacy of the data. In anticipation of this, I approached the research in the tradition of grounded theory, gathering and analysing data in an iterative fashion, each process informing the other. I spent a considerable amount of time in the field reviewing field notes and interviews, and highlighting key themes which emerged in order to aid with analysis later on. This approach allowed me to view inconsistencies and points of interest which further informed my research whilst in the field. The time spent in between my two fieldwork trips also afforded a valuable opportunity to begin my analysis of the data collected in Mali, a process which helped focus my interests for my subsequent research in Ghana.

For the purposes of analysing data, I transcribed recorded interviews and made notes on the main themes of each interview. I also reviewed my own extensive field notes from interviews and observations made whilst in clinics and accompanying staff as they performed their duties in their communities. I highlighted the key themes which emerged from data collected in each location, and reviewed these themes in the context of the role, gender and experience of respondents. This allowed me to view

patterns in approaches common to health workers performing particular roles, and disparities influenced by location, gender, and experience. I then analysed these patterns using a networks approach, focussing on the way in which health workers generated relationships in their communities, and asking what the patterns revealed about the way in which the respective health systems operated.

The activities and observations of health workers were contextualised through data collected from senior health workers and administrators, and through my observational field notes. Both in the field and during subsequent data analysis I took note of comments which appeared several times in interviews with different health workers, a process which assisted in identifying key themes and in verifying the picture of health care provision that was emerging in each context.

Using the coding process principally employed by those undertaking research in the tradition of grounded theory, I reviewed the data extensively with a view to highlighting key behaviour, events and influences. The principal themes which emerged from the research were as follows:

- Health worker strategies
- Gender inequality
- Spousal relationships
- Health worker relationships with communities
- Understandings of contraception and health care
- Understandings of children, family and pregnancy
- Poverty

Having established the key themes, I was then able map connections between them by highlighting patterns in the contexts in which they emerged throughout the research. In this way the identification of these themes was the foundation from which I was able to organise the data, identifying the patterns inherent in the provision of maternal healthcare in the contexts in which I was working and also offering a basis for comparison between the two countries in which the research took place. However, although the process of coding is an essential part of making sense of large amounts of qualitative data, it also has the effect of fracturing data in a way that can obscure key connections between behaviour, events and influences. For this

reason I found that it was important to maintain a considerably degree of flexibility, ensuring that the categories that I had identified and their significance were constantly reviewed as additional data and analysis emerged.

Once I had completed my fieldwork in both Mali and Ghana I continued this process, this time including a simultaneous analysis of the data from both locations which revealed common themes, and highlighted disparities related to the respective community health systems. Through examining data from both locations vis-à-vis one another, I hoped to draw out conclusions about the provision of community maternal health services and the experiences of health workers which would not be visible when examining each context in isolation. I supplemented the analytical process with further reading, particularly with regard to the history of primary and integrated health systems and impact on maternal health care. This allowed me to examine the data from both locations in historical context, and facilitated an analysis of both health systems with a view to generating insights into how integrated health systems might work best for women.

Field adjustments

Apart from the main adjustment in my field location due to the coup in Mali, several challenges became apparent regarding my interlocutors and the nature of the field to which I had to respond. A principal issue was that although the health workers with whom I worked in Mali spoke French, I found that they often preferred to speak Bambara (the most widely-spoken indigenous language in the region), and would sometimes use the two languages interchangeably. I spoke only enough Bambara to make basic greetings, and therefore felt that if I was to put my interlocutors at ease, it would be necessary for me to bring a translator to our meetings to ensure that they did not feel hampered by language restrictions.

There were several issues associated with using a translator, both practical and academic. Finding a suitable translator was not an easy task in Mali. As Devereux and Hoddinott (1992) note in their discussion of the use of research assistants in development fieldwork, whilst RAs may be a boon in a number of ways, finding educated candidates who do not have other constraints on their time may be difficult. In my case there was a further constraint. Men are almost twice as likely to have

completed a secondary school education in Mali, and constituted the majority of people working as translators and research assistants. Since I was to spend the majority of the time working with female health workers in community clinics discussing culturally sensitive topics including pregnancy, birth, family planning and abortion, it was imperative that my assistant be a woman who would be comfortable facilitating these discussions, and who would be accepted by my interlocutors. To resolve this problem I engaged a woman I met through a contact who, although she had never worked as a translator, spoke Bambara, French and some English as well. She was in her mid-twenties with a young child, and in addition to her language skills, her presence during my clinic visits usually aided in creating a good atmosphere for discussion. More generally, she supplied me with a wealth of knowledge about the area, and facilitated good relationships with clinic staff.

Whilst solving some problems, the use of an RA translator generated other challenges during the research process. Principally, where discussions took place in Bambara I was sometimes unsure as to whether the RA had fully translated the responses of health workers, and I noted that in some cases she had chosen to emphasise the elements of their responses which she felt were most interesting. This problem lessened over time as we had more opportunities to discuss the research process and my own language skills improved, but I came to accept that in conducting my research it would be necessary to accommodate her occasional desire to participate in the interviews. This had advantages and disadvantages; in the main I was grateful for her presence as her humour, interest and local knowledge helped to facilitate some extremely informative discussions. Yet she would sometimes steer the discussion in unhelpful directions, or abandon her role as translator all together. Her approach to the role did, however, assuage any concern I had that paying an RA would result in translations skewed towards what she thought I might want to hear.

There were no such language issues in Ghana, as the health workers all spoke English comfortably, both with me and when speaking with one another. There I experienced different problems with interviews, this time with regards to recording and access to particular health workers. The midwife at one of the clinics was happy to talk to me on many occasions and for me to take notes for use in my research, but was not willing to allow me to record our conversations using a digital recorder. This meant that when we talked, it was necessary to make detailed notes of our discussions after

they had taken place. The midwife at another clinic was away when I first arrived, and was unhappy that I had been granted permission to visit the clinic by the district authority without her knowledge. Whilst she was willing to accommodate my visits after her return, I felt that I had offended her, and she was not as forthcoming in our discussions as many of the other health workers with whom I worked.

Both research locations presented general difficulties which impeded day to day research. Frequent power cuts and water shortages hampered the process of writing up field notes, and long journeys using unreliable transport were a regular feature. I also found that health workers' activities often deviated from their schedules. This proved to be an extremely useful observation in terms of my research, but it also meant that on some days I would travel a considerable distance to an appointment I had arranged at a clinic to find that my contact had gone elsewhere for the day. In other cases, health workers were informed at the last minute by the district hospital that they were required for a meeting or training, meaning that they were no longer able to accommodate me. Whilst these incidents were frustrating, they were also very instructive for what they told me about the health systems I was observing.

Locating myself in the research

In both research locations I was highly aware of my own position as a researcher and as a woman working independently on a research project. The speed with which I was able to organise research in both countries through my contacts and my credentials as a PhD student speaks to a position of privilege the effects of which must be acknowledged. The key figures who had granted me access to the clinics in which I worked had the power to instruct health workers to work with me, regardless of their views on my presence. The permission letters I received both instructed the heads of the clinics to accommodate me in no uncertain terms, with one requiring the heads of the clinics to 'ensure that I received a good reception'.

I was concerned that the way in which I had been presented to the staff would prevent me from being able to see their usual activities, interfere with their work, and influence their responses to my questions. On many occasions in Mali I was compelled to reiterate to clinic staff that I did not want to interfere with their duties, and I had to remain very observant in order to ensure that our conversations were not

preventing them from seeing a patient, or delaying them after their shift. In Ghana, health workers were informed of my visit by the head nurse who was known to them, which generally helped to facilitate a more informal introduction.

In both countries I was able to spend a considerable amount of time with health workers, having informal conversations and helping with tasks such as weighing babies, dispensing vitamins as per instructions and looking after children in the clinics. It was in this way that I developed productive research relationships, and many of those with whom I worked shared a wealth of information and observations with me. Helping in the clinics and on child welfare and vaccination days was not only an excellent entry point for participant observation, but also allowed me to assist the health workers who had been so generous with their time and insights.

The fact that I am a female researcher was also a considerable factor in allowing me access to my research subject. Whilst in both Mali and Ghana community clinics are there to accommodate the health requirements of both men and women, they are largely female spaces, staffed for the most part by women and treating mostly women and children. In Mali inequitable gender norms and roles are highly prevalent, where women are traditionally required to defer to the demands of men and to act subserviently (Slegh et al, 2013). The communities in which I worked reflected these gender norms, and one of the most common problems identified by female health workers was situations in which women's husbands or fathers would not permit them to use clinic services. I noted that on the rare occasions when a man visited the clinic with a female family member, he would usually wait in the grounds of the clinic rather than enter. On one occasion when a man did accompany his wife into the clinic for a consultation, the health workers whom I had been observing turned to me and said 'you already know' – I had to leave.

In Ghana, women are also often required to defer to the authority of their fathers or husbands, although patterns of inequality vary widely according to socio-economic factors and lineage (Baden et al, 1994). In Shai-Osudoku, although health workers felt empowered to some degree by their status as government workers and community figures, they too were often troubled by the prospect of challenging men who would not allow their wives or daughters to use the clinic, and some had been threatened by men when traveling alone. Being a female researcher allowed me access to both clinics

and health workers, and facilitated conversations which may not otherwise have been possible. The need for this was compounded by my particular research topic, that of maternal and reproductive health, and the community activities of health workers. It was crucial that I be able to discuss family planning, pregnancy, abortion and relationships with health workers, a kind of research dialogue that would have been far more challenging had I been male. In Ghana I also accompanied health workers when making their home visits, many of them to women whose husbands and fathers were away during the day. This again was a task which may not otherwise have been possible, as receiving a male researcher would have been problematic for the women being visited by health workers.

Much as being a female researcher had many advantages for this particular research topic, it also presented some challenges. Many health workers in both Mali and Ghana were very surprised that I do not have children, and I received some challenges as to why I was researching maternal health care having not had children myself. In Ghana the fact that I was traveling alone became problematic, and I sometimes felt that security was an issue. I found that I was regularly followed, and subjected to a fair amount of sexual comments from men. I could not travel, shop for food or visit areas other than my designated clinics without receiving unwanted attention, which was occasionally prolonged and menacing.

One of the greatest challenges I faced was that of allowing the health workers with whom I worked the space to express their own views and understandings without imposing my own ideals, particularly with regards to the rights of women and notions of equality. This issue is well acknowledged amongst feminist researchers, who face the dilemma of how to approach situations in which our own understandings may challenge or even threaten the perceptions, choices and coping strategies of our respondents (Kelly et al, 1994). This was a particularly stark issue in Mali where although women health workers believed that women should be treated well by their husbands and be allowed to work, they had no knowledge of the framework or language of rights and equality which I had taken for granted. Thus I found myself in a situation in which I referred to 'women's rights', and found that the health workers with whom I was working assumed that this meant 'what it is right that a woman should do'. For this cohort, women's rights constituted having children, cooking, and keeping a clean home.

Through developing reciprocal research relationships I was able to receive useful feedback from health workers on my approach to women's roles and rights. I learned quickly to allow conversations about the position of women in communities and the health workers' perceptions of their own roles to develop more organically, which they did through discussions of their daily activities and their approaches to cases where women were not permitted to use contraception or visit the clinic for antenatal care. This was a strategy which I continued in Ghana, where although health workers were generally more aware of national and international discourses regarding women's equality, it was far more productive to allow them space to discuss these issues in their own way. Again, it was through discussing their everyday experiences that the inequalities experienced by themselves and women in their communities were exposed.

The realities of the field and my focus on maternal health care brought further challenges to my role as a researcher. In both locations the maternal death rates remain some of the highest in the world, and the majority of the communities in which I worked were rural where much of the population did not receive the necessary care during pregnancy. I found in some instances that it would have been unethical to maintain a role as a passive observer. In one such case, a woman visited a clinic in which I was working, having given birth at home the day before and was now suffering severe bleeding. That day the clinic was staffed only by health workers with basic training, and although they suspected post-partum haemorrhage – one of the principal causes of maternal death - they were unable to help her.

The resident CHOs advised her to seek treatment immediately at the nearest hospital, a distance of 16km from the clinic. Despite the protestations of the health workers, she insisted that she would go the next day, because her husband had the money for transport, and he would return then. Under these circumstances, providing her with money for transport to the hospital was clearly right and necessary. In other cases, it was sometimes difficult not to express feelings of frustration when I found health workers had regularly not followed up on cases where women were in need. In these instances, I found that calmly discussing the cases in question with the health workers was very instructive, for this generally revealed deficits in the health system with which the health workers were attempting to grapple.

Ethical issues

This research topic provoked a plethora of ethical issues, some of which I was able to address before entering the field, and some of which I was required to respond to on a case-by-case basis. Due to the fact that I planned to conduct research in clinical settings, I submitted an application to the Research Ethics Review Group at the School of Oriental and African Studies, which was approved. In the ethics review, I addressed my key concerns which were ensuring the anonymity of participants who wished to remain so, keeping sensitive data secure, and ensuring informed consent for participation in the research. I explained the nature of my project to my respondents, assured anonymity where it was required and, despite the commands of the various authority figures who granted me permission to conduct the research, made it clear to health workers that any discussions with me would take place on a voluntary basis.

I found that maintaining the anonymity of health workers who had asked for it, or where I felt it was warranted, was a more challenging task than I first thought. I had envisioned lively clinic spaces staffed by a number of health workers in different roles, but in some of the areas in which I worked there were only two or three full-time health workers, and no clinic in either Mali or Ghana had more than one resident midwife. Further, during my investigations some information came to light which may have incriminated health workers, and I was also aware that my interviews became an outlet for some health workers who wanted a forum to share their own concerns and anxieties. I resolved that throughout my analysis no health worker would be specifically referred to by name, and the names of the clinics under discussion would be omitted where necessary.

Another key concern was that of consent, which in practice was extremely hard to navigate. I have already discussed the potential difficulties presented when health workers are instructed by their superiors to accommodate visiting researchers. Whilst I felt that the majority of the health workers with whom I worked were very happy to participate, I remained concerned that they might not feel able to tell me when they were busy and needed to attend to their duties. In some cases, this meant that the research had the potential to interfere with patient care, something which I was very concerned that I should not do.

Although my focus was on interviewing and observing the activities of health workers, it was clear that my presence would have implications for the patients and community members with whom they worked. I was concerned that observing the activities of health workers whilst they were performing their duties meant that I might infringe the rights of their patients. Here consent was revealed to be a very murky area indeed, as notions of patient privacy, particularly in Mali, were not considered to be a standard part of medical practice as they are in Western medical traditions. In the larger clinic in Mali, patient consultations were conducted in rooms with open doors, with medical and non-medical staff regularly coming and going, and pausing to enquire after their colleagues' patients. It was there that I was invited to attend pre-natal consultations as part of my observations of health workers' activities, a development which raised a number of ethical concerns, particularly as it was a challenge to convince health workers that patient consent for me to attend was crucial.

Health workers in this busy clinic expressed the view that they were in charge of what goes on in the clinic rather than their patients, and did not think it problematic to conduct discussions with patients in my presence or whilst staff came in and out of the consultation room. After I had discussed the issue of consent with health workers, both they and I explained my role, made it clear that I was not medical personnel, and asked each attendee if it was acceptable for me to stay to observe the health workers. I received no objections from patients, and whilst it seemed to me that my presence was unproblematic to them, and in keeping with the rest of the traffic of people entering and leaving the room, it raised the question of how we should address relative medical ethics in research contexts.⁶

I was interested to find that the way in which health workers approached their patients differed in smaller communities where, although again there was no prevalent formal notion of patient confidentiality per se, health workers adhered to notions of trust between themselves and community women, and conducted their consultations in more private environments. In Ghana there were more formal procedures in place

⁶ My concern that the power differential between health workers, their managers and myself would make it difficult for them to protest if they did not want to participate was compounded when it came to their patients. Is it possible to gain consent when the concept itself is alien to the participants involved? The question of whether the way in which we gain consent in such research contexts is appropriate is one that, whilst beyond the scope of this project, I would like to discuss elsewhere.

with regards to seeing patients in the clinic. I was not invited to observe pre-natal consultations, and nor did I ask to do so. Instead, I observed the conversations between health workers and pregnant women which took place during child welfare days and home visits. Whilst child welfare days were public events attended by large numbers of people, home visits were private spaces, and health workers and I obtained consent from each visit recipient. Again I was concerned that community members should not feel obliged to accommodate me.

A further ethical challenge which became a recurrent theme was the desire of health workers for me to participate in treating their patients. Whilst I was observing in clinics in both Mali and Ghana I felt it was important to support the staff in any way that I could. Usually this meant helping to weigh babies on child welfare days, and looking after the children of women who were visiting the clinics. However, despite my having explained that I had no medical training, I found that health workers often expected me to assist with clinical duties such as administering vaccinations, and recording foetal heart rates using a Pinard horn (a wooden trumpet-shaped sound amplifying device). This was one area at least in which there were clear boundaries which I was able to explain; I was happy to perform general duties such as recording baby weights, but could not administer medications or perform any duties for which medical expertise was required.

Photographs

All photographs of people reproduced here were taken with the permission of the subjects where their faces are shown.

Chapter 5: Overview of health provision in Mali and Ghana

The purpose of this chapter is to provide an outline of health provision in these two countries, which contextualises the discussion of health workers' experiences in the ethnographic material which follows. This is also an opportunity to view the community health systems of Mali and Ghana side by side, underscoring the difficulties experienced in both countries in expanding community health services and encouraging the uptake of reproductive and maternal health services. The maternal mortality rates for both countries are extremely high, and the shared health and development histories of these countries provides a compelling context for comparison of the challenges experienced by health workers attempting to advocate women's health services. A discussion of these two countries also reveals marked differences in their development, where Ghana achieved lower-middle income status, and has made significant progress in recent years in developing the role of the community health worker.

The impact of international health policies on the development of community health systems in Mali and Ghana is discussed, and a profile of the decentralised health systems in which community health workers provide maternal health services is provided. Current approaches to community health care in these countries are reviewed, in addition to recent policy developments in each country regarding maternal health care. For each country a profile is provided of the districts in which I conducted my fieldwork in order to demonstrate the way in which health policy is applied in these areas, and to contextualise the lives and experiences of the health workers with whom I worked. Accounts of both fieldwork contexts are underpinned by a discussion of the deep inequalities which limit the opportunities and strategies that are available to health workers and those whom they serve. I have argued that understanding the strategies and relationships brokered by health workers in each location requires both an in-depth analysis of their own activities and understandings, and also an analysis which situates their actions in the structural context of the health systems in which they operate. The data and discussion provided here is offered with

a view to contextualising the activities of health workers in each district that are explored in the following chapters.

Constructing Community Health Systems in Mali and Ghana

As with the majority of African countries under colonial rule, both Mali and Ghana saw health systems develop using Western delivery models designed to address the needs of European administrators, their families and employees. Health centres were built in urban areas, and followed the development of administrative or economic centres, a strategy which meant that health services were largely inaccessible to those living in rural areas. The colonial history of Mali and Ghana left health system structures that were defined by inequality, a pattern which was continued by post-colonial administrations eager to develop hospital services in cities and towns.

In Mali a centralised health system was maintained which prioritised curative health care which was inaccessible to the majority and did not promote preventative measures (World Bank, 1998). Ghana followed a similar pattern, developing the existing centralised health system which focused on hospital-based clinical care, and prioritised health services and sanitation development in port towns and key administrative areas (Dovlo, 1998). In both countries whilst Western medical models were rooted in urban areas, elsewhere indigenous beliefs and practices prevailed, leading to split health care systems in which for the rural majority, traditional healers were more accessible, known and trusted by their communities (WHO, 2002).

The lack of preventative and educative health programmes in both countries post-independence was particularly detrimental for children and women of child-bearing age, for whom measures including vaccinations, health education and antenatal care are crucial in order to prevent maternal and child mortality. In the 1960s the need to address high mortality rates and to combat epidemic diseases such as yellow fever and smallpox became key political issues for the governments of Mali and Ghana, and both countries worked in collaboration with international organisations including the WHO and UNICEF to improve health care provision and services.

International interventions in both countries saw an expansion of health centres covering rural areas which were run by local governments, and staffed by a new cadre of health workers with basic training, taking the countries away from ‘expert-led’ health care models and providing community health workers with basic training. Informed by the Alma Ata declaration on primary health care, both Mali and Ghana introduced primary health care policies intended to further the development of district health teams and community health services designed to make basic health care available in rural areas, and to integrate preventative measures with the provision of clinical care.

The concept of the community health worker became central to primary health care policy development for both countries. Professional and paraprofessional staff working at the village level could provide access to health services to those living in rural areas, and could provide both clinical, preventative and health promotion services. Providing more staff with basic training would reduce the costs of health worker financing, where previously the focus had been on producing highly trained professionals who would work in urban centres. Living locally, health workers would also be able to build relationships of trust with community members, which would aid in their health promotion work and encourage uptake of services (Ofosu-Amaah, 1983).

Ghana developed community health personnel including Field Technicians for Disease Control and Surveillance, Technical Officers and Medical Assistants whose role developed to include preventative as well as curative services (Dovlo, 1998). Mali also developed the role of the community health worker, offering hygienists/first-aid workers and health promoters who worked out of community clinics (Ofosu-Amaah, 1983). Following recommendations from the WHO, primary health care was conducted by community health ‘teams’, which included government and NGO sponsored workers, in addition to Traditional Birth Attendants (TBAs) who performed the majority of deliveries, and who were encouraged to connect with government health workers for advice and to share information.

However, despite significant changes in both countries in response to international health care guidance, the availability of rural health services remained uneven, and development was stalled by political and economic instability. In Ghana, corruption in

the government and military combined with a widening gap between the rich and the poor led to several coups d'état between 1966 and 1981 which slowed progress in developing health services significantly. In Mali, a coup in 1968 placed the country under military rule for the following twenty years, during which time a major drought hit the country, devastating the country's economy, and precipitating widespread poverty, famine and a significant increase in foreign debt.

The debt crisis of the 1980s coincided with the implementation of primary health care, and both Mali and Ghana were compelled by structural adjustment agreements to reduce expenditure on health care. Long term plans for health and development which were developed based on the principles of Alma Ata were never fully implemented. In both countries, the health sector suffered a chronic shortage of funds, and the initial progress that had been made in establishing community health care facilities post-independence was halted. Falling health worker salaries and lack of funds for maintenance and supplies left community health workers demoralised, and working in run-down clinics with little to offer their patients (Cassels, 1996).

Selective primary health care

Rather than the comprehensive primary health care reform that was planned initially, both Mali and Ghana received selective support from international agencies for specific programmes including immunization and Maternal and Child Health, many of which were poorly funded and limited to certain geographical areas. The measures did nothing to bolster health system structures and had no lasting impact on the health of the population, particularly in terms of maternal health care (Maiga et al, 2003). With stagnating community health systems, falling health worker salaries, diminishing household incomes and growing child and maternal mortality rates following the introduction of structural adjustment in many African countries during the 1980s, UNICEF, the WHO and the World Bank coordinated with African governments including those of Mali and Ghana to introduce a scheme which would promote investment in primary health care. The result was the Bamako Initiative, which sought to improve women's and children's health through the introduction of user fees which would subsidise the cost of running community health centres and MCH programmes.

International programmes to implement community management and financing of health services marked a turning point in the community health systems of Mali and Ghana. Provision of health care was refocused towards communities, advocating strengthening services at a district level, and promoting community involvement in paying for and managing services (Jarrett et al, 1992). At the same time, UNICEF had aligned itself with the World Bank in accepting the principle of market-based allocation of health care, and in both countries access to essential medications and treatment became dependent on people's ability to pay.

The argument behind the introduction of user fees was that people already paid for the services of traditional and private healers, and would be willing to pay for community health services if the quality was improved. However, in Mali and Ghana the services of traditional healers were often paid for in kind, or over a longer period, enabling poorer families to cope with costs. Income for many families is dependent on agricultural seasons, and times of low income often coincided with times of illness, meaning that user fees were unaffordable for many rural farming families (Kanji, 1989).

The reality was that the poorest were unable to pay health care costs, which led to low utilisation of health care facilities, and exacerbated the financial hardships of many who did pay (Kraus, 1991). Although the Bamako Initiative recommended exemption systems run by community committees, these were often poorly implemented and in Mali benefitted less than 3.5% of the population (Ponsar et al, 2011). The lack of health system infrastructure in Mali in rural areas meant that the system failed to engage much of the rural communities located more than 15km from a health facility, and many families seeking treatment were compelled to pay full user fees without the support of the community associations which were intended to subsidise fees for those who were unable to pay.

Ghana too failed to successfully implement an exemption strategy for the poor, with emphasis on raising revenue leading to the exemption policy being ignored or labelled as too difficult to implement, whilst the Ministry of Health failed to adequately monitor the fee collecting system (Badasu, 2004). With declining budget allocations and decreasing supplies, health centres managers began to set and collect their own fees, and whilst they were successful in maintaining their operations, the neglect of

exemption policies led to a 'sustainable inequity' in which health centres continued to function whilst preventing the poorest members of the population from accessing services (Nyonator and Kutzin, 1999)

The introduction of user fees was particularly detrimental to maternal health in these countries, presenting a further barrier to accessing antenatal care, particularly for the poorest women living considerable distances from health care facilities. In both Mali and Ghana women face both social and physical barriers to accessing health care, bearing an inequitable burden of providing food and care for their children, which generate both financial and logistical problems in accessing health care for themselves. Women also have a disproportionate need for expensive clinical services due to their need for reproductive health care (Nanda, 2002).

In Ghana, the introduction of user fees precipitated a decline in the number of antenatal care visits, supervised delivery and postnatal visit attendance (Agyepong, 1999). The quality of services, mistrust of government health workers and logistical problems accessing facilities were already significant problems, which were exacerbated by the introduction of fees. In Mali, the introduction of user fees led to reduced attendance for antenatal care and delivery, and further reduced women's agency in making health care decisions on behalf of themselves and their children. In their study of the hidden costs of user fees in Mali, Johnson et al (2012) highlight the gender inequality which was deepened by the introduction of user fees, in a country in which the majority of women have little or no control over household expenditures.

For community health workers, the introduction of user fees was a mixed experience. Many experienced a drop in the demand for their services, and their capacity to build trust in their communities was significantly undermined by the prevailing view that fees went to line their pockets rather than in payment for medications. User fees were intended to cover non-salary clinic operating expenses, meaning that health workers did not directly benefit from the payments that were made to the clinic. In some cases, health workers were documented asking for under the table payments of fees in order to supplement their meagre salaries, a practice which, whilst it allowed them to top up their income, further undermined their position of trust in their communities (Nyonator and Kutzin, 1999).

Focus on community health systems

Whilst the introduction of community-managed user fees had widespread negative impacts on the uptake of services, the principle of district management marked the foundation of the decentralised health systems operating in these countries today, including the network of community health workers who operate in rural districts in these countries. Mali set up community health care associations (Associations de Santé Communautaire) known as ASACOs to run community health centres, to which members paid an annual fee and received consultations and medications at a reduced price. Health workers lived and worked in the communities which they served, and reported to the chief of the clinic in which they worked, who in turn would report to the ASACOs. Ghana also made considerable efforts to develop services at a district level, implementing many elements of the Bamako initiative, including developing community health committees, community financing of essential medications, and crucially, the development and training of voluntary and paid health workers drawn from local communities (Phillips et al, 2006).

While both countries successfully established the principle of community-led primary health services, Mali's progress has been slower, hindered by severe health sector funding restrictions. Building on the expansion of district health services, the World Bank participated in the development of Mali's National Health Policy, particularly through the 1991 Health, Population and Rural Water Project (PSPHR), which focused on boosting the capacity of district health management teams to plan and supervise services. According to the World Bank's Independent Evaluation Group (1999), much as there were small improvements, the project was critically undermined by severe inequities and lack of resources.

Despite real progress in expanding local health services, utilisation remained low particularly due to unavailable or prohibitively expensive transport, with high risk groups including rural women and children being least likely to take up the services. The project also suffered from the lack of funding available from the government for basic health staff, and poor training meant that staff did not have the skills necessary to use the referral system appropriately. Health worker morale was further undermined by the process of transferring management to the district level, with many feeling a lack of control over their clinics and roles on the basis that poorly

managed community associations had the power to withhold their salaries, hire or fire them (Knippenberg, 2003).

In Ghana, initial efforts to mobilise community action for primary health care were also fraught with difficulties, but many improvements were made in the 1990s following lessons learned from a variety of experiments with different cadres of community health workers. The Ministry of Health implemented several campaigns designed to expand community health services, initially focussing on the use of community health volunteers to generate affordable health services in remote areas. The results of Ghana's volunteer programme were disappointing, showing a high turnover of volunteers, poor quality of care, poor communication between district management teams and the national health system, and persistently vertical systems of management (Adjei et al, 2001).

In response to criticisms of the volunteer approach, the Ministry of Health began to focus on developing a new type of paid health workers known as Community Health Nurses (CHNs), who could offer more professional and effective services. By 1990, over 2000 nurses were trained and working, but the majority of them worked in sub-district health centres, making them inaccessible for many living in surrounding areas. Attempts to perform community outreach services were mostly unsuccessful due to logistical problems which meant that communities were not aware when services would be available (Nyonator et al, 2005).

In 1995, the Ministry of Health experienced a significant breakthrough, with a project known as the Navrongo experiment, which sought to marshal underutilised social resources such as community groups, chieftaincy and social networks to improve the efficacy of health volunteers, whilst simultaneously moving CHNs into community health centres where they would live and work. Renamed Community Health Officers (CHOs), nurses were trained to provide both clinical and advocacy services in their communities. The success of the Navrongo experiment in increasing accessibility and uptake of services led to the creation of the Community Health Planning and Services Programme based on the model, which is now the basis of community health care in Ghana today.

Community health workers are now the first port of call for the majority of people living in rural areas in Mali and Ghana, and play a significant role in bridging the

divide between communities and the formal health system. In both contexts, the majority of rural health workers live in the communities in which they work, providing opportunities to connect with villages and community authorities in order to promote clinic services. Retention and motivation of community health staff in both countries has been a consistent problem due to lack of resources, isolation, and difficulties integrating with communities (WHO, 1989). Yet for both countries, the expansion and strengthening of community health services has continued, making health services available to many remote communities, and contributing to falling mortality rates, especially amongst children and infants (GHS, 2010; DHS, 2012). The challenges faced by community health workers today are complex, and require them to perform daily negotiations between the realities of the lives of those they serve and the demands of their district managers, whilst carving out a life for themselves in their communities.

Overview of development indicators and current health provision in Mali and Ghana

Since the Alma Ata Declaration, the health ministries of both Mali and Ghana have directed much of their resources towards developing community-based health systems, and have faced similar challenges in their efforts to establish health care providers in rural areas. Although progress has been made in both countries, particularly in Ghana with the development of the CHPS programme, today each has a high maternal mortality rate which they are attempting to tackle through continued development of community health care infrastructure and targeted maternal health financing policies. In other respects, as shown in Table 1, the profiles of these countries differ considerably, with Ghana emerging ahead of Mali in the majority of basic indicators.

Table 1. Mali and Ghana: Selected population, human development, poverty and health characteristics

	Mali	Ghana
Population (millions)	15.3	25.9
Annual population growth rate 1990-2012 (%)	2.8	2.5
GNI Per capita 2013 (US \$)	670	1,760
Total population below income poverty line (US \$) (%)	43.6	24.2
Total adult literacy rate 2008-2012 (%)	33.4	71.5
Total fertility rate (per woman) 1970	6.9	7.14
Total fertility rate (per woman) 2012	6.9	3.9
Modern contraceptive prevalence rate 2008-2012 (%)	9.8	34.3
Adjusted maternal mortality rate (per 100,000 live births)*	540	350

Source: UNICEF, 2014a and 2014b, World Bank, 2014a

* UNICEF, WHO and UNFPA evaluate data reported by national authorities and make adjustments to account for the pervasive problem of underreporting and misclassification of maternal deaths.

Today, Mali remains one of the poorest countries in the world, and is heavily dependent on official development assistance, which accounts for 30% of all national expenditure. The fact that the population is spread over sparsely populated territories undermines efforts to make basic service provisions for many communities, and leads to severe geographical inequities between regions. The economic structure is largely based on agriculture and fishing, and for many, opportunities for generating income are seasonal and dependent on the unpredictable desert climate. In order to generate enough income to survive, many people are necessarily engaged in a number of different economic activities throughout the year. The undiversified economy makes the country particularly vulnerable to commodity price fluctuations.

These factors, combined with unfavourable climatic conditions and the political instability which has characterised its development, contribute to high poverty rates and persistent problems in increasing availability and uptake of health services in rural areas. Despite the fact that Mali has made significant improvements in health care in recent years, the country has some of the worst health care indicators in the world. Uptake of contraception is extremely low whilst the fertility rate has remained high, and Malaria is a persistent threat, all factors which further contribute to the country's critically high maternal mortality rate. Although there have been concerted efforts to develop community-managed health services, expansion has been slow, and the overall health infrastructure is weak with a severe deficit of clinics and trained health workers in rural areas.



Fig 6: Selling fruit in a market, Mali.

Photo by the author.

Ghana has experienced more profound successes in a number of development targets over the last twenty years, having halved the number of people living below the poverty line, greatly reduced child mortality, and substantially increased the coverage of health and education facilities. Ghana also has one of the fastest growing economies in Sub-Saharan Africa, and achieved the status of a lower middle-income country in 2010 (IMF, 2014). However, the country's phenomenal economic growth rate has not been matched by many of its development indicators, particularly in rural areas.

Whilst significant progress has been made overall, there remains a strong geographic disparity whereby nearly 40% of people living in rural areas live below the poverty line, compared to about 28% living in urban areas (World Bank, 2014b). This geographical inequity is also evident in the significant disparity in coverage and quality of both health care and education services available in rural areas. Large disparities between urban and rural mortality rates persist, and maternal mortality in particular is an area in which progress has been far slower than in other indicators. In 2008, Maternal Mortality was declared a national emergency. Problems of accessing health services in rural areas are acute, and use of family planning, maternal and child health services is low. Many district and community facilities suffer from intermittent water supplies, poor sanitation facilities and a serious lack of skilled health workers in rural areas.

In order to address high maternal mortality rates, community health workers in both Mali and Ghana perform a significant amount of advocacy work in addition to providing clinical services including family planning, antenatal care and delivery. However, the social component of delivery has become more formalised in Ghana through the development of the CHPS programme, where CHOs are trained and placed in order to provide preventative and promotive services in the communities in which they live. For both countries, the current challenge is to increase the availability and quality of community health services, with a view to providing both accessible clinical services, and preventative and promotive services which are vital for increasing uptake of services and reducing their maternal mortality rates.

Mali health system profile

Mali's Ministry of Health (Ministère de la Santé) is responsible for health policy and provision, and works in conjunction with international agencies on implementing health and development projects. Health policy is implemented through the Ministry's Health and Social Development Programme (PRODESS), which was launched in 1999, and health funding stands at 8.4% of state budget allocations (Paul, 2011). Mali's health system is decentralised, and organised over four key levels (see fig. 7). There are severe shortages in fully qualified doctors, and as of 2009 there were 729 registered doctors in Mali, less than 1 per 10,000 people. The shortage of health workers in general is far more acute in rural areas, reflecting the general development of the country in the post-colonial period skewed towards urban centres. Community clinics (CSCOMS) are usually staffed by matrones, who have six months training and basic maternal and triage skills. Individual CSCOMs are run by a head nurse, or a doctor where available, and a limited number have a sages-femmes on staff. Communities are also serviced by relais who usually have 5 days training, and provide basic health information and support in their communities.

The health service delivery design is a pyramid structure, with around 20,000 relais reporting to CSCOM staff, who in turn report to community health associations. Community health care works via a referral system, whereby volunteers refer patients to CSCOMs, and CSCOMs refer patients to district referral centres or hospitals where necessary.

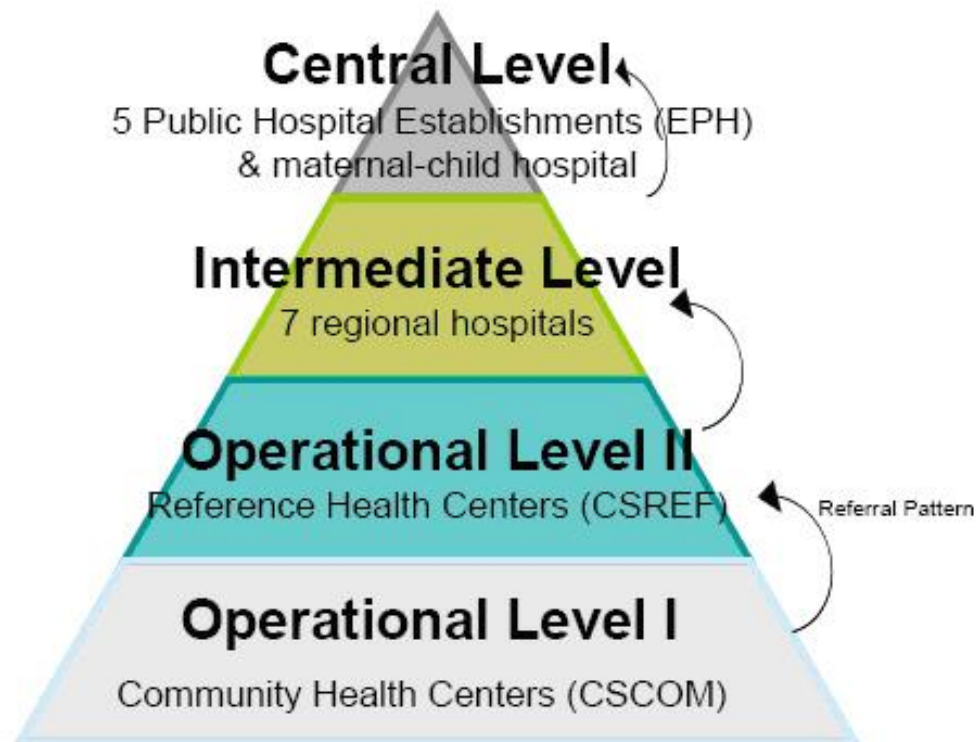


Fig 7: Mali Health Care System Structure

Source: compiled by the SAMSS secretariat, 2009

Approximately 50% of health care expenditures are out of pocket, and inefficiencies in cost recovery mechanisms between CSCOMS and ASACOS have increased the cost of both health services and pharmaceuticals (USAID, 2013). The government's health financing strategy now includes investing in health insurance schemes, which are currently operational in a limited number of communities, covering under 5% of the total population. In the majority of rural areas, families receive no financial support to help with the cost of health care, meaning that the poorest people are least likely to seek health services.



Fig 8: Cooking area at a CSCOM, Mali.

Photo by the author.

These inequities are also reflected in the geographical distribution of health services, which is heavily biased towards urban areas. With regards to the availability of medical personnel, Mali overproduces health workers relative to the rate of absorption in the capital, but due to poor incentives to work in rural areas, there remains a situation in which there is very uneven coverage, and dire shortages in rural areas (WHO, 2010). The country has one physician per 8,646 people, one nurse per 1,947 and one midwife per 11,413 (USAID, 2013). The relais' coverage of remote areas is uneven, and the most qualified health professionals are based either in Bamako, or regional capitals.

As a result of the decentralisation of health service management, the majority of lower level health workers in the region are hired from within the local area, meaning that they are familiar with the community in which they work, and are less likely to leave to take up posts elsewhere. Matrones in particular have often been providing health services in their communities for most of their adult lives, and have built a wealth of knowledge about the lives, beliefs and health requirements of the people they serve. This is less true of highly skilled health workers such as doctors and sage-femmes; whilst some know their communities very well, many were trained in the capital and move posts regularly.

Health workers continue to suffer the politics of accountability generated by the process of decentralisation, due to the fact that whilst they are managed by ASACOs, they remain accountable to both local government and the Ministry of Health, who may reverse hiring or salary decisions made at the local level. Parallel and complex lines of management and accountability demotivate community health workers, and lead to situations in which health worker responsibilities are poorly defined (Lodenstein and Dao, 2011).

A further challenge for the health service in addition to providing clinical services, is implementing effective measures to promote healthy behaviour at the individual, household and community levels. This includes outreach work designed to educate regarding use of mosquito nets, child and maternal nutrition, and the importance of attending a health facility for antenatal care and delivery. Currently, there are multiple different organisations carrying out health advocacy work in the country, many working to train local health volunteers. One such programme, Keneya Ciwara which is run by CARE Mali, focuses on increasing the availability of basic health information and services at the community level. The programme works with partner NGOs to train relais in order to raise awareness of family planning, child and maternal health care and nutrition in areas where the population lacks access to local health care facilities. In some cases relais are trained by the staff at their nearest CSCOM, and report there for supplies and training.

Relais are selected by their village communities, and usually receive seven days training before they assume the role in their communities. According to CARE (2009), providing relais with a title and certification helps them to gain the trust and respect of the community which is vital to their advocacy work. Villages are requested to select two relais, one male and one female, who are each responsible for thirty-five households. Education levels amongst relais in rural areas are low, with a considerable number unable to read or write. These community volunteers are not paid, and occasionally receive token payments or gifts known as ‘motivation’. Where relais have supplies such as condoms and cycle beads to sell in their communities, they are sometimes able to make a small profit from the sales.⁷ Relais spend about ten hours a

⁷ Cycle beads were developed as an alternative to medical contraceptive methods for use in areas with low uptake of family planning services, and are designed as a visual aid for women to plan based on their fertility cycles. Rolled out in Mali in 2002, the cycle beads initiative has not been as successful as predicted, suffering in particular difficulties raising awareness amongst women, and inability to attract

month completing their community health duties, work which they must complete alongside their regular income-generating occupation.

Whilst in theory the relais constitute a principal means to connect remote populations with health care education, advocacy and services, the scheme is severely under-financed and under-developed, leading to patchy coverage, and poor levels of training and supervision. A 2009 evaluation of the role of community health volunteers in Mali showed that 38% of relais had not received any further training or supervision since they were initially engaged, and even fewer had contact with their nearest community health facility. Although the scheme was initially designed with the intention that the relais would be supervised by staff at the district hospital, this did not materialise (Perez et al, 2009). The study also found that in areas which are covered by relais, only half the number of households surveyed had received at least one visit from a relais in the three months preceding the survey. 81% of the relais interviewed for the study said that the training they had received was too short for them to fully understand the requirements of the job, and that they were not supported by supervisors.

There are significant communication issues between health volunteers, CSCOMs and ASACOs, which further undermine the benefits of the scheme. There are few records kept of their training, few opportunities to provide feedback, and attempts to increase the motivation available for them have been largely unsuccessful. In order to fully implement the promotive, educative and advocacy elements which are vital to improving health at a community level, the ministry of health will need to fully invest in the training, supervision and remuneration of relais, in addition to empowering paid community health workers to take on more advocacy work in addition to their clinical duties.

Maternal health care in Mali

In 2005, the government introduced a free caesarean policy in public sector facilities designed to improve access to emergency obstetric care and alleviate alarming maternal health indicators. The fee exemption was applied to the direct costs

buy-in from the community health volunteers who were intended to sell the beads in their communities (Manriquez and Denend, 2012)

associated with the procedure, including the equipment required for a caesarean, surgical costs, post-op treatment, hospitalisation and laboratory costs. The policy is financed entirely by the government's health sector budget, and as of 2011 had been implemented in 57 health facilities, comprising regional hospitals and referral health centres (USAID, 2011b). The measure has meant that more women have access to emergency obstetric care, and the overall rate of caesareans has increased from 0.25 to 1.5 % between 2003 and 2012 (Fournier et al, 2014). However, the policy has had limited success, especially in rural areas where there has been no significant change in the numbers of women receiving a caesarean, regardless of whether their village has a health care facility or not.

The policy only covers specific direct costs, meaning that transportation to an accredited facility, other medical costs and indirect costs most often fall to the patient and their families. The problem of transportation for obstetric emergencies is one of the principal problems of the scheme, and the weakness of attempts to create community solidarity funds to help cover costs has placed an unmanageable financial burden onto households. The result of this is that the poorest women who are most at risk are unable to benefit from the free caesarean policy for financial reasons. The scheme also suffers from a lack of resources and weak communication between health facilities in rural areas. The referral system is often difficult to maintain in rural areas with no electricity, poor telecommunications and difficult road conditions. In these areas there are also ambulance shortages; many districts have no ambulances at all and rely on public transport, and of the emergency health transportation that is available, many vehicles are in poor condition or non-functional. Referral facilities in many districts also lack general resources, including a shortage in supply of government-provided caesarean kits, and shortages of blood and drugs.

In addition to the burden of costs associated with accessing emergency obstetric care, the free caesarean policy has also been rolled-out predominantly in larger, urban-based facilities, which compounds the problem of access for poor, rurally-based women. The majority of women receiving free caesareans live in cities with district hospitals; amongst this demographic the rate increased from 1.7% before the policy was introduced, to 5.7% in 2012 (Fournier et al, 2014). Overall, the free caesarean policy benefits urban, wealthier women, whilst the rate of caesareans amongst rural populations has remained too low to alleviate the risk of maternal death. In order to

address this, it is essential that the health service address both the coverage of facilities equipped to provide emergency obstetric care, and also the access issues which preclude women from benefiting from these facilities. This includes addressing not only the financial barriers, but also the social barriers connected to women's subordinate position in society. Addressing this aspect will require an integrated approach targeted at poor women, which utilises community health workers and education programmes to empower women to seek the care that they require (El-Khoury et al, 2014).

District profile: Kati

Located in the south-west, the district (cercle) of Kati falls within the Koulikoro administrative region, and has a population of 948,128 according to the 2009 census. The district is divided into communes, which are governed by community councils. The population lives predominantly in rural, farming communities, where poverty and economic instability are principal risk factors for poor health. Educational levels for the Koulikoro region are low, particularly for women of whom only 23% have received any formal education (Mali DHS, 2012). According to official data, women have an average of 6 children over their lifetimes, although the actual figure is thought to be higher given the under-registration of births in the region (Mali DHS, 2012). Access to health care is a challenge for many people, as over half the population of the district lives more than 5km from a health facility. Problems accessing health facilities are compounded during the rainy season, which renders many of the roads unusable, cutting off transport links to clinics.

The cercle of Kati is the largest health district in the Koulikoro region with 2 referral centres, 51 CSCOMs and 38 sage-femmes. However, distribution of health care personnel within Kati is critically uneven, with CSCOMs based in the town of Kati having a more comprehensive staff than those in more remote parts of the cercle (CADMali, 2011). Doctors and sages-femmes are scarce in rural areas, and many CSCOMs do not have a midwife on staff. The majority of paid health workers in the district are matrones, who are well known in their villages and are often the first port of call for maternal health services and information.

Health workers at all levels often work in difficult conditions, and have seen a variety of government and NGO initiatives implemented over the years with mixed results. The majority of CSCOMs in rural areas of the district have no electricity or running water, and many are dilapidated and under-equipped. Beds and medical equipment are occasionally supplied as part of the implementation of NGO-led projects, but these are often not replaced when they wear out. CSCOM walls feature health campaign posters provided by the Ministry of Health, which are typically faded, and out of date. The experience of health workers depends in part on where they are posted in the district, with conditions, locality and available funding determining their salaries. Sages-femmes working at referral centres generally earn more than their counterparts in CSCOMS, and for all those working in community clinics, the pay varies considerably from clinic to clinic. Health workers living and working in communities with no electricity are often isolated, and unable to communicate regularly with district health authorities or their families, a fact which is a marked deterrent to increasing the number of sages-femmes and doctors working in rural clinics.



Fig 9: A CHPS compound in Ghana.

Photo by the author.

Ghana health system profile

The Ghana Health Service (GHS) is responsible for planning and implementing national policies for health delivery, and manages the overall resources available for the provision of health services including financing, infrastructure and human resources. Although public health expenditure in Ghana is low for a lower middle income country, it has been higher than average in West Africa since the 1970s, currently standing at 10.7% of total government spending (Burke and Sridhar, 2013). Policies are developed and implemented by the health service in line with the 1993 health system decentralisation reforms, and today the service is responsible for increasing the capacity of districts to manage and extend health services in their areas.

Health services are run on an integrated basis between levels from the national to the sub-district (see fig. 10). At the regional level, curative services are provided by regional hospitals, while public health services are undertaken by district health management teams working in conjunction with regional hospitals. District and sub-district health care facilities are supervised by regional health administrations. This structure is replicated at the district level, where curative services are provided by district hospitals, and public health services are run by district management teams working with district hospitals. District health administrations supervise the facilities in the sub-districts located in their jurisdiction.

District hospitals are the lynchpin of district health services, providing clinical care, surgical and diagnostic services and trained health care personnel in addition to hosting district health administrators and running training events for community health workers. They serve populations of between 100,000 and 200,000 people, and are equipped with between 50 and 60 beds (GHS, 2014). District hospitals are the referral point for community health workers operating in sub-district health care facilities.

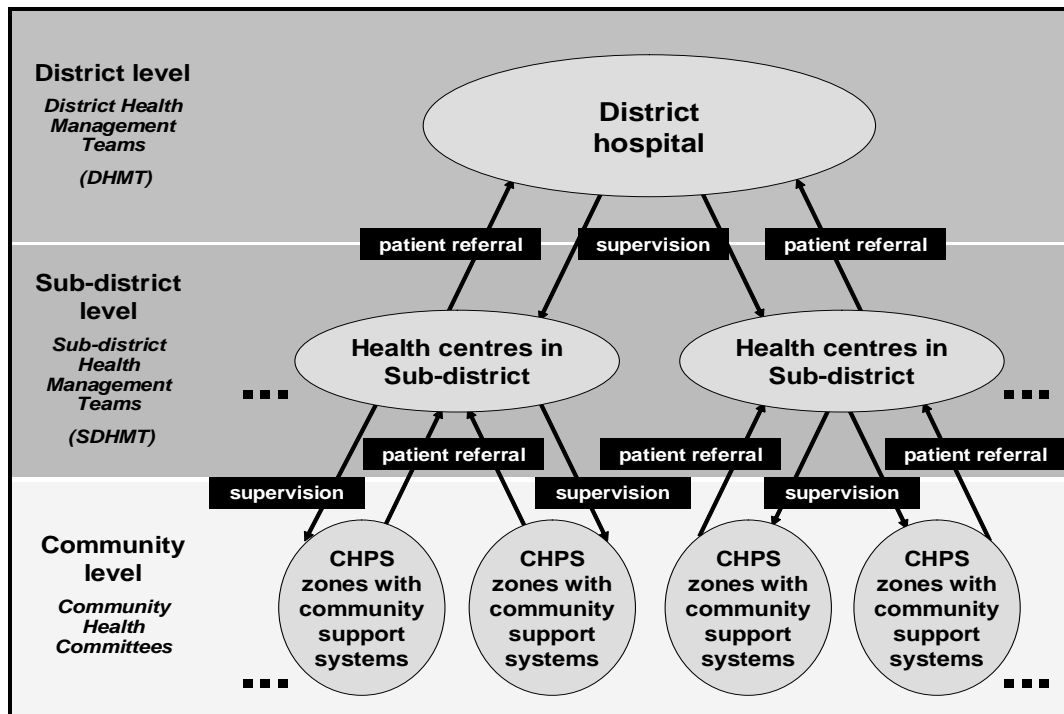


Fig 10: Institutional Structure of the Ghanaian Public Health Service.

Source: (Nyongator, 2013)

The sub-district is the level at which the majority of both preventative and curative services are provided. Sub-district health centres are the first stop for many seeking medical treatment, and provide treatment for minor ailments, immunizations, and basic reproductive and maternal health care. They increase their service coverage by undertaking community outreach programmes including immunizations and child welfare, school and church visits, and operate a referral system whereby severe or complicated cases are referred to the appropriate next-level facility. Community clinics are usually staffed by a midwife, CHOs provided by the CHPS programme who perform basic maternal and child health checks and advocacy services, and registered nurses who perform triage duties.

Ghana is one of a handful of African countries which has introduced a national health insurance scheme. From 2003, the NHIS has been working with health care facilities to recruit members, and according to their figures, 34% of the population use the service. Scaled-up from individual community-based insurance initiatives, the national programme has attempted to address the needs of poor and vulnerable groups by implementing insurance exemptions and various benefits. However, the

implementation of the programme has been difficult, and the health service is faced with the challenge of making affordable benefit packages available and finding ways to target vulnerable groups, in addition to logistical issues of claims processing and payment, and ensuring that the necessary health services are available. Implementation of these benefits on the part of the health service has been slow, as have efforts to reimburse health centres for the services they provided under the scheme. Enrolment amongst the poor is very low, and the majority of subsidies are awarded to hospitals, which excludes much of the rural poor. 66% of the population does not have health insurance, and the costs of the scheme are prohibitive to the point at which the scheme runs the risk of bankruptcy (Schieber et al, 2012).⁸

Much of the burden of health financing falls directly on the population; 47% of all health spending is private, with the majority of those funds paid out of pocket (WHO, 2009). Out of pocket expenditure on health care is currently twice the threshold recommended by the WHO, a fact which has severe implications for the poorest families for whom health care costs are prohibitive. An analysis of Ghana's national health insurance scheme indicates that 64% of the richest members of the population are registered with the NHIS, compared with 29% of the poorest (Oxfam, 2011).

One of the greatest inequities of Ghana's health financing system is the fact that the poorest 20% of the population pay 6% of their expenditure as tax, a significant portion of which goes to fund the health budget, which also funds the national insurance scheme (Akazili, 2011). Therefore, not only are the poorest families paying taxes which they cannot afford, they are also unable to pay for the national insurance which would allow them to use the services that their taxes help fund. Inability to afford national health insurance is the main reason given for not joining the scheme by 85% of people in rural areas, and 91% of people from poor households (NDPC, 2009).

Maternal health care in Ghana

In 2008, the Ghana Health Service introduced the Free Maternal Health Care initiative, which was implemented through a health insurance waiver for pregnant

⁸ The figures of health insurance coverage are widely disputed by right-to-health advocates who estimate that actual valid NHIS coverage could be as low as 18% (Oxfam, 2011).

women. The programme offers subsidised health insurance which provides maternity care, and is funded by the national health insurance fund with contributions from international partners via the general health service budget. However, although the scheme provides free pre-natal and delivery care, it does not cover ambulance or transport costs, post-partum care, comprehensive family planning services or counselling. The initiative has facilitated a significant increase in the number of deliveries taking place in an accredited health care facility, but there remain profound disparities in the services available and uptake of services in rural areas.

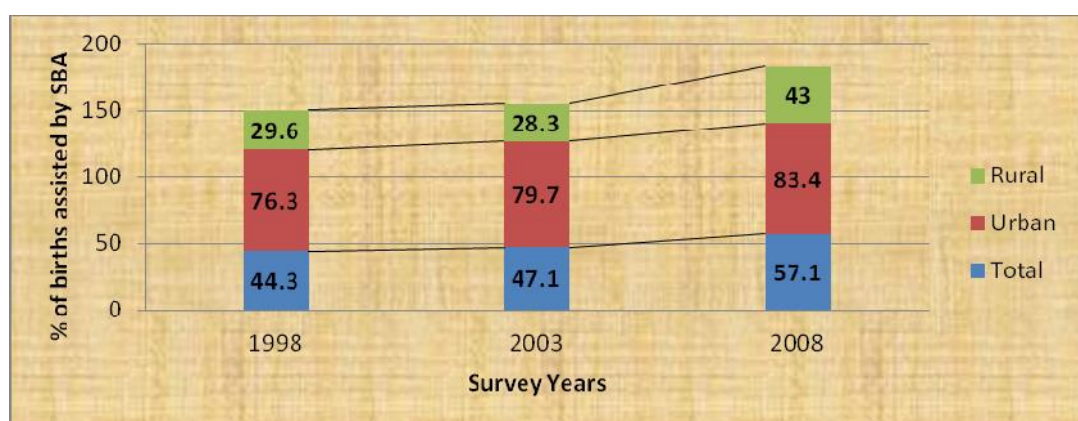


Fig 11: Skilled Birth Attendant (SBA) at birth (1998–2008)

Source: GDHS, 1998, 2003 and 2008, reproduced from NDPC and UNDP, 2012

57% of births are currently attended by a skilled health care professional, whilst district hospitals are struggling to cope with the increase in deliveries. The principal problem for district facilities is a shortage of health workers, but facilities also suffer from lack of resources, with some hospitals unable to offer caesarean sections, and some suffering from intermittent water shortages (HERA-HPG, 2013). User fees for ambulance services or public transport remain a significant barrier to accessing available services.

Community health planning and services

The CHPS initiative was pioneered through the Ghana Health Service in order to replicate the results of the Navrongo community health and family planning project. The results of pilot studies suggested that providing resident nurses increased the interactions of community members with health services by eight times that of district

health centres (Nyonator et al 2005, Pence et al 2001). In particular, providing resident health workers improves access and uptake of maternal health services, and increases the likelihood that women living in rural areas will attend 1-4 antenatal care appointments (GHS, 2011). The CHPS initiative is now considered the key to providing health care services to those who previously had little or no access, and forms part of the national poverty reduction strategy (Nyonator et al, 2005). A key component of the initiative involves mobilising community nurses to create partnerships with households, social groups and community leaders, 'addressing the demand side of service provision and recognising the fact that households are the primary producers of health.' (MOH, 2009).

This feature of the project responds to calls from international agencies for health services to make use of the social resources of communities, including social networks, community organisations, lineages and chieftaincies. In recent years, national and international development institutions have demonstrated a renewed interest in understanding the social causes of health sector inequalities. In particular, addressing the geographical and socio-cultural aspects of inequalities that exist in global health systems has become a primary goal which has informed the administration of community health care, leading to health care policies designed to create 'synergy' between the social aspects of health care and the provision of clinical services (Yazbeck, 2010). The programme is also designed to address the 5th millennium goal of improve maternal health care through increasing access to services by improving the coverage provided by skilled nurses and midwives, who conduct antenatal care and deliveries. CHOs are required to monitor pregnancies in the area, conduct pre-natal consultations and report to the midwife at their compounds where one is resident.

The process of scaling up the CHPS system relies on a successful 'community entry' phase, in which a dialogue is established between the Health service and the community at hand. The project must gain community support, especially from traditional leaders who must offer their support for the project. This is achieved through extensive research on the social systems and leadership structures at work within the community, in addition to gaining greater understanding of the work of traditional healers operating in the area. Talks are established with key figures, which are designed to secure support and resources from the community for taking the

project forward. Often, officers from the health service will utilise *durbars* (community meetings during which music, dancing and discussion take place) as a space in which to foster discussion and feedback on the introduction of CHPS to the area.

In order to effectively deliver CHPS services, it is necessary to build a community health compound in an appropriate location, which serves as both clinic and living quarters for community health officers. In addition to CHOs, it is intended that a midwife also be posted to CHPS compounds, which will feature a room for antenatal consultations, a delivery room and living quarters for the midwife. Building the facility requires significant input from community leaders, who are responsible for mobilising resources and volunteers for the construction of the compound.

A crucial way in which the delivery of health services differs from that which was previously offered by district health centres is the training of CHOs to prepare them to live in the community whilst carrying out both clinical and advocacy work. CHOs provide all aspects of primary health care, including family planning, antenatal and postnatal care, immunisations and treatment of minor illnesses. In addition to this work they also play an active advisory role, and are the first community port of call for health education. Empowering CHOs through providing training in the areas of social mobilisation is intended to provide communities with a new generation of health workers who are culturally aware, and able to act as conduits between households and the health system.

This approach is designed to improve community health care twofold, both instrumentally, by providing doorstep access to health care providers, and pedagogically, by changing the way communities relate to health care providers and the health system (Acquah et al, 2006). To this end, community midwives and CHOs are required to network with traditional birth attendants in their communities, with a view to ensuring that a midwife is either present at the delivery, or able to arrange a follow up visit to check on the progress of women and their new-borns.

After a successful implementation phase, health workers are supported by community health volunteers (CHVs) who provide health education services and keep community records in partnership with CHOs. CHOs will keep residence at the community health compound in order to provide clinical care, and are also expected to make regular visits to the households of community constituents in order to provide family

planning services, pre and post natal advice, health and hygiene education and early detection of ailments. They also run regular outreach sessions in prime locations in the communities in which they work, including childhood immunisations.

Throughout its implementation, the CHPS programme has been steadily expanding the number of functional health care facilities available in rural areas, principally through the training and establishment of CHOs in CHPS zones. This has resulted in an improved nurse to patient population ratio, which stands at 1,240:1, and an increase in the number of CHPS Clinic compounds to 6,500 (MOH, 2014). The CHPS programme has brought health services closer to many rural populations, which decreases the amount of time women seeking health care spend on non-economic and non-household duties. In addition to providing clinical services, CHOs also act to promote behavioural change and encourage positive health-seeking activities. The benefits of improved health worker coverage can be clearly observed in the drop in under-5 mortality from 128 per 100,000 live births in 1990 to 72 per 100,000 live births in 2012 and the successful treatment of infectious diseases such as TB (UNICEF, 2014b).

However, the success of the programme to date has been mixed, especially in the area of maternal and reproductive health. Although fertility rates have fallen in recent years, rates remain high especially in rural areas where the rate is estimated to be 4.9. Use of family planning methods for all 15-49 year olds stands at 34%, and at 17% for married women, while unmet need for family planning is estimated to be 35% (MOH, 2014).⁹ Family planning coverage has shown little improvement, and actually fell from 31.1% in 2009 to 23.8% in 2010 due to erratic funding available for community health care interventions (GHS, 2010).

Antenatal coverage stands at 48.9% and has increased only marginally over 5 years, and an estimated 40% of births in Ghana are unattended by any skilled health care personnel (MOH, 2014). The maternal mortality ratio has fallen from 410 per 100,000 live births in 2010 to 380 per 100,000 live births in 2013, indicating that Ghana will not achieve the Millennium Development target of 185 per 100,000 live births in 2015 (MOH, 2014). Despite the many improvements which have been achieved as a result

⁹ Unmet need is defined as situations in which women who are fertile and sexually active are not using any method of contraception, and report not wanting to conceive, or wanting to delay their next pregnancy (WHO, 2014d)

of the CHPS coverage, access to health care remains highly unequal between urban and rural areas. Funding for district and sub-district level expansion of services remains erratic, and there are far too few trained midwives and CHOs available in rural areas.

The Ministry of Health is currently heading a campaign to steadily increase the number of community health workers available, with a goal of achieving full coverage at a ratio of 1 CHW to 500 people in the next ten years. However, a comprehensive gender assessment concluded that the CHPS programme does not adequately accommodate women's time and mobility constraints, their decision-making patterns or their participation in health planning at the inception of a CHPS project in a community (USAID, 2011). Further to this, they also note that health and care are considered the duties of women in the majority of cases, and therefore the advantages of community-based approaches must be assessed against the cost of the extra time and workload to the women to whom these responsibilities fall. Integrated health services are essential to tackling ill-health, the causes of ill health and problems of access, and are needed most by women who face complex social and economic barriers to health care. The challenge for CHPS moving forward will not only be to improve coverage by trained health workers, but to improve the delivery structure, social and advocacy side of their programmes in order to accommodate the needs of women in the communities they serve.

District profile: Shai-Osudoku

Health care for the district of Shai-Osudoku is managed by an administrative body operating out of the hospital in the district's principal town of Dodowa. Situated in the Southeastern part of Ghana in the Greater Accra Region, the Shai-Osudoku is a large district of about 721sq.km with a population estimated at 72,525 (GHS, 2014). The district is almost entirely rural and contains about 145 settlements, the majority of which are comprised of subsistence farmers, and fishermen along the coastal areas. Many families, particularly migrant workers from the northern Volta region, live in temporary wattle-and-daub houses known as *Adanesi*, whilst others live in concrete compounds which often house several families who share resources. Poverty is widespread in the district, and the area is typical of other rural districts in southern

Ghana, where health centres are sparsely staffed and equipped, and are often few and far between.

There is one main tarred road which traverses the district via the capital Dodowa, which is in poor condition. The majority of the villages are accessible by dirt track only, and during the rainy season, some areas of the district are impossible to access without four-wheel drive (Indepth Network, 2006), meaning that some communities are isolated for a significant part of the year. Furthermore, the population of Shai-Osudoku is diffuse, which compounds the difficulty and expense involved in traveling to and from each community in the district. The majority of motor vehicles are buses and taxis, the latter being too expensive for use by many of the population. Bicycles are one of the most popular forms of transportation, however district health officers generally conduct their community visits on foot, or hitch rides in a government-owned vehicle should one be passing by their compounds. Although the district capital is just 40km from Accra, there are no telephone cables, meaning that communication by phone and internet is facilitated via mobile phone networks alone.

The recently accredited Dodowa Hospital in the district capital is the centre for health care administration, and the base to which CHWs, midwives and health volunteers report for training, medical and administrative supplies. The CHPS programme is currently being rolled out in the district under the supervision of the district health director, the district's head nurse and the CHPS coordinator, all based at the hospital. Under the programme, the district is divided into areas known as CHPS zones, with the ultimate goal that a CHPS compound be built with the cooperation of the community, and serviced by CHPS officers and a midwife. There are currently 10 functional CHPS compounds in the district, and 7 fully-trained midwives, not all of whom are based at CHPS compounds. As the programme is implemented, CHWs are placed in each of these zones, and provide services from their houses until such time as a CHPS compound is constructed.

In addition to government health workers, there are more than 300 traditional healers working in the district, and about 180 traditional birth attendants, roughly half of whom have received some level of training from the Ghana Health Service. Under official programme guidelines, the CHPS coordinator should visit each CHPS zone once a quarter, in order to monitor their progress and record any concerns raised by

CHOs. However, the reality is that, since the vehicle used for the purpose broke down several years ago, the CHPS coordinator is rarely able to make the requisite visits to the zones, and supervision of CHOs by the district administration is haphazard. Many CHOs in the district are recent graduates, and are unprepared for the pressures of the dual role they are required to perform when they are placed in their communities. Many feel isolated, and look forward to the days when they are permitted to travel to the nearest town for training or a day off.

Gender and poverty: how uptake of community health services is shaped by inequality in Mali and Ghana

From the outset, community health systems in Mali and Ghana have been characterised by complex inequalities which operate both on structural levels in the pattern of development of services and health financing, and in local contexts in which entrenched societal values regarding the role of women compound barriers to accessing health services. The history of development in both countries is defined by urban bias, which has led to health system implementation that is skewed towards urban centres, alongside the development of transport, energy and water facilities which are all crucial in widening access to health services and attracting skilled health workers. The poverty gap between urban and rural areas in both countries is significant, and the introduction of user fees for health services hit rural areas the hardest, where many people are unable to pay for health care and the transport costs required to access services.

In both countries, the inequalities inherent in patterns of the development of health systems and financing have had the most detrimental effect on poor women living in rural areas. Women occupy a subordinate position in both societies, and men make the majority of decisions regarding household expenditure and uptake of health services. Women are responsible for managing domestic life including childcare, and must maintain these responsibilities regardless of whether they are also engaged in paid work. Fertility rates in both countries are high, and there are widespread cultural objections to the use of family planning methods. Women of child-bearing age are therefore in a uniquely disadvantaged position whereby they require a significant level of health care associated with multiple pregnancies over their lifetimes, and are often

unable to access the services they require due to constraints on their time and the control of men over household expenditure.

Mali

Although the subordinate position of women undermines access to maternal and reproductive health services in both countries, the situation for women in Mali is particularly grave. For women in Mali, opportunities for access to health and control over their bodies are profoundly limited both by the law, and widespread social norms that dictate that women are required to submit entirely to their father or husbands. The country introduced a national gender policy in 2010 designed to promote egalitarian values and boost opportunities for women in the public sector, yet the policy has had little impact, and implementation has been stalled by severe lack of resources and political will at the level of local government (UNDP, 2011).

The Malian constitution contains many regulations which are discriminatory towards women, the most damaging of which are contained in the country's Marriage and Guardianship code, which places men in charge of households, and requires women to seek permission from their husbands in order to work or spend household finances. Where women are permitted to engage in income-generating activities, their social obligation to maintain their household duties are not diminished, meaning that working women are burdened with dual roles (UNDP, 2011). Primary school enrolment rates for girls are an average of 10% lower than for boys, with girls expected to assist their mothers with household duties in addition to attending school. The legal marriage age for women is 15, and one in two women are married before the age of 16.5 (Mali DHS, CPS, 2014). The legal marriage age for men is 18, and men are permitted to marry up to four wives. Although the Marriage Code has been the subject of intense protest from national and international women's campaigns, a plan to amend the code to improve women's rights was vetoed in 2012 after enormous pressure was placed on the government by conservative Muslim and cultural associations across the country.

In addition to those which are enshrined in law, there are many societal customs and values which prevent women from exercising control over their health and bodies. Although domestic violence is illegal, it remains a widespread and socially acceptable

means for husbands to discipline their wives, and is therefore rarely prosecuted (Bleck, 2011). Uptake of contraception is extremely low, and the practice is widely condemned due to fears of lasting infertility, the prestige attached to having many children, and the belief that contraceptive use encourages women to be promiscuous. Many women who use hormonal contraceptives do so in secret, a strategy which some women discontinue for fear that the disruption caused to their menstrual cycles will alert their husbands to their clandestine use of contraception (Castle et al, 1999).

Female genital mutilation (FGM) is widely practiced in the country and affects over 90% of women. FGM is practiced across both ethnic and religious lines, although specific customs vary according to local cultural beliefs. Women who have not undergone the procedure are not considered eligible to marry, and parents who refuse to submit their daughters for the procedure are subject to social pressure and potential ostracisation (USDS, 2001). Although Mali has adopted a national plan for the eradication of FGM which involves supporting education and sensitization campaigns, there is no formal legislation outlawing the practice. The practice of FGM has a significant bearing on maternal outcomes, with women who have undergone FGM being significantly more likely than those who have not to experience obstetric complications. According to a WHO study group investigating FGM and obstetric outcomes, FGM is estimated to lead to an extra one to two maternal deaths per 100 deliveries (Eke and Nkanginieme, 2006).

In addition to posing significant barriers to women seeking health care, the subordinate position of women in Malian society seriously undermines the capacity of health workers to promote reproductive and maternal health services in their communities. Gage (2007) notes that in addition to financial and transport issues the low status of women and concurrent difficulties in gaining permission from their husbands to access services is a principal barrier to accessing maternal health care. The majority of community health workers are women, who not only struggle to promote these services in areas where poverty and cultural beliefs are prohibitive factors, but also to garner the credibility required to successfully advocate women's health services in patriarchal communities.

Ghana

Ghana has made a considerable amount of progress in establishing legal frameworks for the protection and enhancement of women's rights. The Ghanaian constitution prohibits any form of gender discrimination, criminalises FGM and forced marriage, and specifically addresses the issue of domestic violence. However, despite major political advancements in the enhancement of women's rights at a constitutional level over the last ten years, many women do not receive the benefits of this legislation. As in Mali, implementation of gender policies have been hindered by lack of resources and widespread adherence to customary practices, and many existing laws which protect women are not well implemented.

Gender inequality remains a key feature of social life, and reflects both deeply embedded historical social structures and complex kinship systems. Ghana's historical structures of kinship, trade and governance were predicated on gender values which have significant bearing on the position of women in the country today and the opportunities available to them. During the colonial period, women were excluded from many of the traditional roles they played in society, and their subordinate position in society was reinforced. Post-independence, development initiatives continued to draw on many of the existing patriarchal social structures, resulting in persistent social and gender divides. Customary practices which dictate that households are headed by men and allow polygamous and early marriage are still adhered to by much of the population.

Women are also particularly vulnerable to poverty due to their economic roles in society. Almost half the population living below the poverty line are food crop farmers, a role which has traditionally been the domain of women (ADF, 2008). Women suffer more generally from systematic inequalities which prevent them from accessing critical resources such as land and credit, and lack of decision making powers over distribution of resources in male-headed households.

There is also a pervasive lack of representation of women in influential positions at both district and national levels. Women currently represent about 10% of parliamentarians, a statistic which places them at 120 worldwide, and well below many other West African countries including Togo, Burkina Faso and Sierra Leone.

Women's political representation at the district level is also extremely low, and has actually fallen in recent years. Women face various constraints which prevent their participation as political actors, including time constraints due to family and household duties which are predominantly considered to be their responsibility, and cultural values which prevent them from securing financial support, and reduce their ability to become independent actors (USAID, 2011).

Women's lack of political representation is also reflected more broadly in society, where women encounter a triad of barriers to participation as leaders and decision makers; cultural, financial and logistical constraints all severely impact women's political prospects, as well as their ability to participate in civil society organisations and to take up positions of power in society. Oppressive cultural and religious views of women's role in society are widespread, education levels for women are lower than those of men, and husbands and partners often restrict women's activities through emotional or physical abuse (Tsikata and Darkwah, 2009).

One of the most odious effects of gender inequality is the numerous barriers to accessing health care that it produces. A principal challenge for the health service will be to design services which accommodate women's time and mobility patterns, in addition to their needs and health care preferences. Poor health service quality and coverage in rural areas disproportionately affects women, for whom time and mobility constraints are key factors in accessing health care. Women's work, household and childcare duties often prevent them from accessing clinic services during opening hours. Transport is another significant issue, as it is often too far for women to walk to their nearest health care facility, especially if they have young children, and the cost of public transport may be prohibitive (USAID, 2011).

In the majority of households men control family resources and are the primary decision makers, a fact which severely impedes women's capacity to access health care, especially with regards to investment in antenatal care, skilled delivery and contraception. This issue is often compounded by the fact that health workers and programmes regularly exclude men from their educative and advocacy work regarding maternal health care, the result of which is that men who have the decision making powers over seeking health care are often unable to appreciate the need for it (Greene et al, 2005).

Although the development of community health services has improved access to reproductive health services, uptake remains low due to pervasive societal attitudes regarding family and contraception. Women who use contraception face considerable risk of family conflict and ostracism by their communities. Having numerous children is valued for both cultural and economic reasons, and low fertility is considered damaging to family status and economic potential. According to Adongo et al's study of women's reluctance to adopt family planning in Ghana (1997), few women view decisions about family planning and use of contraceptives as theirs to make, adhering to the customary understanding that men make decisions regarding families and households.

As in Mali, health workers are faced with the task of advocating reproductive and maternal health services in patriarchal communities, where contraceptive uptake is low and women have few practical decision making powers over their uptake of health services. CHOs, who are mandated to perform regular preventive and promotive work in their communities, spend much of their time discussing the benefits of family planning and the importance of antenatal care with individual women, their husbands, and with community groups in an effort to change attitudes and encourage uptake of services. Midwives also connect with TBAs in their communities in an attempt to coordinate messages about the importance of ante and postnatal care, although they often experience limited success in their endeavours due to concerns on the part of TBAs and local religious groups that midwives undermine customary birthing practices, and steal the livelihoods of TBAs (Ganle, 2014). Community health workers face a formidable task in their mandate to encourage uptake of services, and for some CHOs, youth and inexperience are significant problems.

As women, community health workers are already at a disadvantage when advocating services with village leaders, a fact which is often compounded by their youth. In cases where community health workers have been raised in traditional families, they sometimes go on to perpetuate negative attitudes towards women themselves. A Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) report for Ghana (2005) notes that in some cases negative attitudes of health workers towards women in regards to abortion, pregnancy and use of contraception when unmarried are further barriers to women accessing these

services.¹⁰ There are also many documented cases of community health workers in Ghana going beyond their mandate to support women in their communities, and they remain key figures in promoting and expanding the opportunities of women to access reproductive and maternal health services (Mayhew, 1999).

I have outlined the development of community health systems and the roles of community health workers in Mali and Ghana, and provided profiles of the health systems as they operate today in the districts in which I conducted my research in these countries. The profile of health systems in both countries included a discussion of the deep inequalities which underpin women's experience of accessing reproductive and maternal health care, and the concomitant challenges faced by community health workers attempting to advocate these services in their communities. The following chapters provide an in-depth, ethnographic discussion of the experiences and strategies of community health workers in Mali and Ghana as they attempt to integrate educative and advocacy work with the provision of clinical services.

¹⁰ Abortion on the grounds of physical or mental health, serious foetal abnormality, rape or incest was legalised in Ghana in 1985. However, this clause was included in the country's criminal code, which has contributed to the stigma surrounding abortion and the belief in many areas that it remains a criminal offence. Whilst the Ministry has recently developed a working policy on abortion, there is little evidence that safe-abortion services are available in public health institutions (Aniteye and Mayhew, 2013).

Chapter 6: Mali ethnography

In this section I discuss the ethnographic data collected while researching maternal health care provision in the Kati district of Mali, and pick up some of the theoretical themes which have emerged from this research. The health care workers I describe here were involved in the practice of creating and maintaining community networks for maternal health care on a daily basis, a process which I view as an effect of the particular kinds of maternal health system in which they were operating. In the section that follows, I provide a picture of the district clinics and activities of the health care workers with whom I conducted my fieldwork, and demonstrate the techniques they used in order to generate the community networks which were necessary to fill the gaps in the maternal health care systems in which they worked. The formal health care system in which the health workers operated will be discussed, and examples will be provided which demonstrate the limitations of the formal system with regards to reproductive and maternal health care in the district.

The activities of health care workers operating within this system are then examined in detail, an exercise which highlights the multiple strategies they developed with which to further maternal and reproductive health care agendas in their communities. The most striking element which emerges from this analysis are the networking activities undertaken by health workers, who on many occasions involved themselves in advocacy work which extended far beyond their roles as medical service providers, and traversed the boundaries of the clinics in which they were posted. These strategies are interesting not only for what they tell us about how health workers enact the practice of maternal and reproductive health care on a daily basis, but also for what they indicate about the particular conditions under which maternal and reproductive health services were delivered.

Although health workers enjoyed many successes through their advocacy work and were generally considered to be trusted community figures, there were also times when they were not able to operate beyond the bounds of their assigned roles as medical service providers. Throughout my work in Kati it became apparent that instances in which networks for furthering maternal health care failed to reproduce were equally instructive, indicating the multiple challenges faced by health care

workers attempting to further maternal health care uptake and provision in their communities.

Informal networks: constructing community health worker relationships

The doctors, nurses, matrones and sages-femmes working in CSCOMs were often expressed feelings of attachment to the people communities in which they worked, particularly in areas further from the capital with smaller populations to cater for. Some had lived and worked in their communities for many years, and took great pride in the trust and responsibility that went with their roles. Although they were not mandated to offer medical consultations outside of the clinic or engage in advocacy work, for many this was the foundation of their social role and status within their communities. In the smaller communities in particular, there was no expectation that their work at the clinic be kept separate from the rest of their lives, and they were quite prepared to see patients at their houses for help and advice, or to advocate use of the CSCOM in their daily conversations. Notions of trust (*la confiance*) and *noblesse oblige* were recurring themes amongst many of the health workers regardless of their status in the health system, and their commitment to their communities took precedence over health service regulation, which for many of them seemed very remote. None but one of the clinics in which I worked in the region had an electricity supply, and contact with health service representatives was few and far between, especially for the matrones who rarely left the villages in which they worked.

In one clinic the *médecin chef* would offer his services for free where patients were unable to pay, and would sometimes pay for medications himself:

If they visit and have no money we do give them medication, and after if they have money they will come and pay then. There are some people who never pay. But I have an obligation to help them. It is my decision to do this because if someone has a problem we must help. If I know the women haven't got money sometimes I pay so there is no deficit for the CSCOM and I won't get into trouble.

Here the *médecin chef* expressed an obligation to his community which went beyond that which was required by his role at the clinic, and illustrated the role he played in reconciling his obligation to the community with his obligation to the ASACO which

financed the clinic. A nurse working in the same community expressed a similar sense of obligation which went with her role, and was keen to point out that although she was well acquainted with women in her community and would often treat them at her house, she did so not because she was their friend but because she was obliged to help anyone who required her assistance:

I have to help anyone who has a problem. I don't help because they are a friend, I help because they need it.

Along with a sense of obligation, the notion of being a trusted figure in the community played a significant role in informing the health workers' sense of self and their roles as health care providers. The majority of matrones and sages-femmes agreed that this was the aspect of the job that they enjoyed the most, with several commenting that it was 'la confiance' of the community with which they were endowed that was the most rewarding aspect of their role. As one matron explained to me, her official role was to provide family planning and deliver babies, not to provide secret consultations, but this is a natural part of the job when one has a role such as hers in the community:

Some women come and they have problems in the family, problems with husbands. It's a secret! It's just between us and the woman. They trust us, it's natural. But secret consultations are not part of my job at the CSCOM, just planning and delivery.

Many of the health care workers were emphatic on the point that reaching out to their communities with information about contraception and maternal health care was one of the most important aspects of their work, although their activities in this area extended far beyond that which was required by the health service. They cited talking to men about allowing their wives and daughters to use the clinic and about the value of contraception as one their key roles, in addition to educating women about seeking appropriate maternal health care. Forging good relationships with village chiefs was also considered an important means via which to advocate for the clinic, as they were best placed to advise men who were reluctant to allow their female family members access. Harnessing their positions in their communities, health workers were able to connect the CSCOM and maternal health care agendas to those with whom they lived in the area, making the clinic a more present and relevant part of community life.



Fig 12: A médecin chef's office in a CSCOM, Mali.

Photo by the author.

Some of the staff wielded a considerable amount of influence over the health care strategies taken up in their communities, especially in areas in which the médecins chefs were able to forge good connections with community leaders in order to advocate use of the clinic. The strategies employed by the health workers can be understood as generating community health networks which sought to recruit members and share information about maternal and reproductive health care in ways which might be understood by their communities. In harnessing their roles in this way, many health workers became permanent and effective conduits for sharing maternal and reproductive health information in their communities. The following diagram illustrates the connections that were forged and maintained by different actors in the process of furthering women's maternal and reproductive health care:

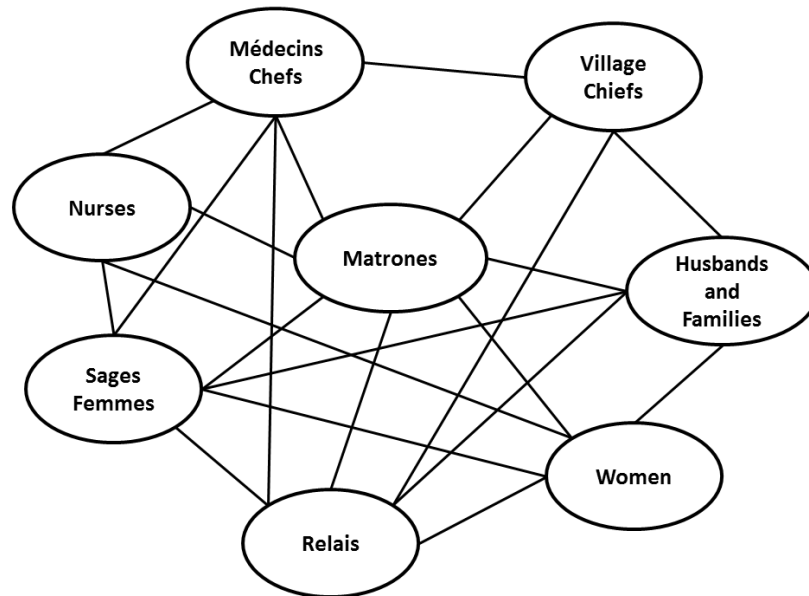


Fig 13: Health care Networks in The District of Kati

The majority of the health workers recognised the importance of establishing and maintaining a rapport with local authority figures in the communities served by the clinic, and would go out of their way to build these relationships where they could. This was a strategy which was principally conducted by the *médecins chefs*, who were more often in a position to travel to the surrounding communities and were more likely to be able to influence the decisions of those in authority. This approach was particularly effective in communities such as Dio Gare and the surrounding area, in which village chiefs continued to wield a considerable amount of influence, and were able to intervene in the private matters of their constituents.

The *médecin chef* at Dio Gare was aware when he moved to the clinic that the area had a complex political history, most recently featuring tensions over the construction of the current CSCOM in the 1990s. At one time the area had been a trade hub on a now-disused railway line between Bamako and Dakar, the legacy of which was the formation of several villages nearby the original village of Dio, populated by both the native Bambara people, and a number of migrant families from northern clans. When the time came to construct a new clinic building, the decision was taken by the health service to move the location from that of the original vaccination post in Dio, to Dio Gare, where it would be more accessible to a greater number of the local population.



Fig 14: A clinic waiting area, Mali.

Photo by the author.

The decision to build the clinic in Dio Gare rather than in the original village of Dio caused considerable bad feeling in Dio, which led to a period of civil unrest which remains very much in the social memory of the communities in the area. The *médecin chef* understood the need to connect with authority figures, especially those who felt disenfranchised by the decisions regarding the clinic, in order to ensure that the clinic benefited as many people as possible. As such, he spent a great deal of his free time traveling to surrounding villages on his motorbike, visiting with chiefs to keep them informed as to the clinic activities and to advocate use of the clinic, especially for antenatal care and family planning. In particular, he emphasised the importance of birth-spacing in order to reduce maternal and child mortality, and asked the chiefs to help advocate the department of health's birth-spacing policy in their villages. Where he was aware of cases in which a husband was preventing his wife from using the clinic, he would take up the matter with the chief:

Many do not want to do planning. That's why I go to the villages and explain to the chief. They think that if you do planning you will not be able to have a baby any more but I explain it is not for that. It is just to have some years between babies. It is not difficult, but you need two or three years between them.

Dio Gare's médecin chef's awareness of the political history of the region allowed him a greater understanding of the communities in the area and their relationships with the clinic, insight which he was able to use to advocate maternal and reproductive health care services. In comparison with other clinics in the district, the politics of the region with which he had to grapple were particularly complex, but his willingness to engage with the communities with whom he was posted was by no means unique. All médecins chefs of the clinics in the district had access to a motorbike which they used to visit as many of the villages surrounding their clinics as they could. Notably, the médecin chef in Digao would visit the surrounding villages frequently, and made himself available to those who needed him by ensuring that his mobile telephone number was known in the villages. He would often leave the running of the clinic in the hands of the sage femme, and visit the villages to respond to calls from those who were unable to visit him at the clinic, or to visit the homes of patients with whom he wanted to follow up.

The médecins chefs in the area would also extend their connection to their communities by working closely with the relais, and placed particular emphasis on educating them as to the best way to talk to people about maternal and reproductive health care such that it might persuade them to seek help with pregnancy and family planning at the clinic. The médecin chef at one clinic would invite the relais based in the surrounding villages to training days at the clinic, during which time he would hold discussions as to the best way to advocate clinic services in addition to providing the training he was required to give on the merits of birth-spacing and the different forms of family planning:

I explain to them how people can do the family planning, but also how to talk to people. If you want people to do planning you have to tell them that it is not for never having a baby. If you have two or three children you can look after them but more than eight, nine, ten, you can't look after them. They can't go to school, you can't have money to buy them food. This is how they must explain to people. I talk to the relais and use a blackboard for training. I can't write for them; there are some who can read but some not.

In addition to performing outreach work in their formal capacity as medical providers, the health workers based in the district would take opportunities during their leisure time to educate people regarding maternal and reproductive health care, advocate clinic services, and provide medical care and advice for those in need at their own

homes. The majority of the staff worked and lived in the communities served by their clinics, and were well known in the surrounding area. This provided them with ample opportunities to spread information about maternal health care and clinic services in their communities, rather than waiting for patients to come to the clinic. Health workers did not limit their networking activities to their discussions with patients and their families, and often maintained their agenda of furthering the maternal and reproductive health of women in their daily lives away from work.

The strategies they employed in their roles at the clinics were maintained throughout their daily interactions with their communities whether they were 'on duty' or not. Médecins chefs, sages-femmes, nurses, and matrones all reported having been approached in their villages, with a particularly common request being from women who wanted to visit them at their houses in order to receive a contraceptive injection in private, or to ask questions about malaria and pregnancy. A recurring theme was that health workers were keen to help those in their communities when they could, but lamented that they were not always available because they spent the majority of their time at the CSCOM which many were unable to reach. None of the health workers professed to charge for advice or services rendered outside of the clinic. As one matron explained, it was not unusual for women who lived near her to come to her house for advice, and she would not think of charging them for the consultation:

Some women come to my house and ask me about planning, malaria, infection and pregnancy. I explain to them. These are women who live in my village. It's free, I don't charge for knowledge! But sometimes I sleep at the CSCOM so I cannot always see them at home when they come to visit.

Some of the health workers were also prepared to provide medical services at their houses, in particular for women who wanted to conceal their use of contraception from their husbands and families. One sage-femme explained to me that on the occasions on which she was approached privately for help with family planning, she would instruct the women to buy the necessary materials and come to her house where she would administer the injection:

I do injections at my house. I do not charge for this. People buy the serum and needles from a pharmacy and I will do it for them.

Particularly for matrones and sages-femmes living in more remote areas of the district, being approached for health care advice when off-duty was a regular occurrence which they understood as a natural consequence of their role as health care providers. However, some would also take a more active role in their communities, approaching young women and pregnant women in order to advocate use of family planning or to find out whether pregnant and post-partum women in their village had arranged the necessary clinic visits.

One matrone said that if she knew that a woman in her village had recently given birth, she would tell them to watch out for blood or pain and go back to the clinic straight away if that happened. She would also approach pregnant women outside of the clinic to instruct them as to the right foods to eat, tell them to use a mosquito net, and tell them to come and see her at the clinic for a pre-natal check-up. Vitally, she would also tell them how to plan the birth, when to come to the clinic, and what to expect. She instructed women that their birth plan needed to include transport to the clinic, and money to pay for the equipment needed, both factors which often prevent women from seeking delivery at a health care facility. Emphasising the importance of getting maternal health care information out into the community as much as possible, she said:

It is important to share all of this information when you can, in order to have normal births and help women to stay well. That is why the relais are very important as well – they spread the word about mosquito nets, good food and pre-natal visits.

The majority of sages-femmes and matrones said that they would ensure that any pregnant women they knew of received information about healthy pregnancy and preparing for the birth, and would strongly encourage them to visit the clinic in order to be monitored during their pregnancy. Some were also compelling advocates of family planning in their communities, taking the opportunity to talk to young women and women with many children about the merits of controlling their fertility.



Fig 15: A poster urging pregnant women to ensure that they have transport to a facility if a caesarean section is required.

Photo by the author.

This was articulated in particular by one sage-femme, who said that being well known in her community gave her an opportunity to offer advice to women about contraception, and the importance of maternal health precautions such as using a mosquito net, taking anti-malarials and visiting the clinic at least four times for pre-natal check-ups. She was very keen to emphasise the importance of family planning, and went out of her way to educate young women in her village of the benefits of waiting to have children, advocacy work which she viewed as a key part of her role:

If I meet a girl in the village and I know her family, I might say "how are you, and your family? I see that you are getting older, do you know about family planning? You don't want to have a baby, you want to study. It is dangerous to have a baby when you are young..." All girls should use it. If they have their menses, they should do planning. But not all sage-femmes think so... They have to do it - I'm not going to force them but who will look after the baby, their mother or father?

This sage-femme was more outspoken on the issue of family planning than some of her counterparts, a fact of which she was well aware. There did not appear to be a consensus amongst the health workers in the district as to the right age or

circumstances under which contraception should be administered, and this requirement of their roles was in large part open to the individual interpretation of the health worker in question. Whilst the majority of matrones and sages-femmes were willing to help women who wanted to use contraception regardless of their age or marital status, they were less likely to openly advocate it for younger or unmarried women. Additionally, where they did help younger women with contraception, they sometimes felt obliged to conceal their actions from the médecin chef of their CSCOM. During interviews with a junior doctor in charge of one clinic and the matrones who staffed the clinic, it emerged that the doctor's personal approach to this issue differed markedly from that of the matrones of whom he was in charge. The doctor would not prescribe contraception for younger women even with parental consent, believing that it would encourage young women to be promiscuous:

There is a problem with planning. The other day a woman brings her daughter 14 years old for consultation for planning. She has her period, she wants planning for her daughter but I say she is too young. It is not for young women because it can lead to complications when you get married and have a baby. If you give contraception to girls they will get STDs and have lots of boyfriends.

The matrones working at the clinic had a different view, and during group conversations they explained the dilemma they faced when young, unmarried women approached them asking for contraception. They were concerned that very young girls should not have sexual relationships, but they were all prepared to give the contraceptive pill to girls aged thirteen and over. The issue that gave them particular concern was the fact that many of the young women who approached them requested the contraceptive injection, which is considered unsuitable for younger patients who have not had children. As one matron explained during a group discussion:

Here, girls can't talk to their mothers about boyfriends, but some as young as 10 have boyfriends and have sex. It is very dangerous. 16 is the age that they are supposed to be allowed contraception. If the girl is 9 or 10 you can't do planning it is bad for them. Younger girls shouldn't be having sex with their boyfriends, planning is not very good for them. They can have a complication if they get married. We got family planning from Europe. The first training I did they said the tablets are ok for younger girls. Injections and implants are for if you've had a baby. But now, everybody here wants to have the injection without having a baby. This is dangerous, there can be complications. I will give them tablets, but they don't want them because they forget to take them. And they don't want people to see. But I will give tablets to young girls. We are not allowed to do this here but we

do. But at 13 years old they come here and say they forget to take tablet and they want the injection. We say no, and they go to the pharmacy. They just need to give them money and they will do it for them at the pharmacy. It is dangerous.

When not attending to patients, the matrones at the clinic would often be found sitting outside in a circle sharing green tea, which gave them opportunities to discuss such issues. They were in agreement that women thirteen years and above should be given access to the contraceptive pill, although the doctor residing at the clinic expressed a different view. However, they faced more of a dilemma over the contraceptive injection, knowing that if they refused to administer it to younger women that it was likely that they would seek it at an unregulated pharmacy. Dirty needles and counterfeit medicines at such establishments are a significant concern, in addition to the fact that the young women they turn away may well become pregnant at a young age, something they want to help them avoid due to the higher risk of complications during pregnancy.

Many of the health workers in the district demonstrated considerable understanding as to the most effective way to discuss maternal and reproductive health care with both their staff and volunteers, and the communities in which they worked. Although their training had taught them the various advantages of using clinic services including family planning and maternal health care, they developed numerous strategies of their own for explaining the necessity of reproductive and maternal health care services in ways which they expect the people they are talking with will find most appealing. These strategies ranged from discerning the most effective points to emphasise when advocating clinic services to different people, to teaching women how to advocate clinic services themselves such that they would have a better chance at persuading their husbands and families to allow them to use the facility. Health workers who were well known and respected in their communities felt able to give advice to women as to how to discuss their reproductive and maternal health care needs with their husbands. After listening to women describe the objections of their husbands, they would 'translate' their advice in such a way that women would be able to use it to change their husbands' minds.

I was told of one of the most striking examples of this process of translation whereby a nurse practitioner had developed her own strategies for advocating the clinic

services. She described an event which had recently taken place, in which a woman with many children had come to the clinic to ask for a contraceptive implant because she was ill and exhausted. A few days later her husband, having learned of this, brought her back to the clinic and demanded that the implant be removed. The nurse and a matrone at the clinic attempted to explain the risks of his wife continuing to have children, but to no avail. Because husbands have ultimate control over their wives' health care, the staff were forced to remove the implant. This, said the nurse, is an example of why you have to learn to approach men in the right way:

There are men who don't understand about contraception. It doesn't mean you won't have a baby again. I tell them, if you don't understand, come to see me at the clinic. If they won't, I go to them with the matrone, and we say you can have money problems if you have too many children. If you explain like this, lots more men are ok with contraception. When they are not, like the man who came in with his wife, I explain to the wife, go home and explain to your husband. He won't want to listen in front of us in the clinic, but when you go home you are at home with him only. Tell him about the money problems he will have with more children, and you can tell him that you need to be well or you could die with lots of children. I see husbands and wives come back in together after this to do family planning.

In addition to advising women on the best ways to discuss family planning and pregnancy, it was not unusual for sages-femmes and matrones to intervene in cases where a woman's father or husband would not allow them to use contraception or in cases where women's husbands would not permit them to seek help from the clinic during their pregnancies. For example, the sage-femme and matrones at one clinic in which I worked were quite willing to visit the houses of women who had reported these issues to them, and would explain the benefits of family planning and the importance of monitoring women during pregnancy to husbands and parents in an effort to make them reconsider their decision. As one matrone explained:

I talk to a girl's father or husband if they won't allow women to use family planning. I explain that it can be very bad for the family if the woman has a baby young, or if she has too many babies. Sometimes they don't want women to use family planning because they think this means she will have a lot of boyfriends. I call them to the clinic and tell them that having lots of children is expensive, and explain that if the woman dies there will be nobody to look after the children. Sometimes they listen and sometimes not.

Several of the matrones I interviewed said that the best way to explain the need for women's health care services to their husbands and parents was by using economic explanations, which emphasised the direct and indirect financial deficits which occur when women have children when they are young, or when families do not practice birth-spacing. Having many children presents a significant financial burden, in addition to the fact that should women die from complications due to multiple births, the earning capacity of their husbands and families would be reduced as they would have to take time to care for the children without the mother. When they were talking to women about the maternal health benefits of contraception health care workers were more likely to emphasise the benefits for the woman's health, and discuss the effects contraception would have on her body and fertility.

They would also explain she would have more time for her existing children, and emphasise the importance of allowing time to care for one new baby before having another. Yet the guidance offered by individual health care workers varied according to their personal experiences and beliefs, and those such as sages-femmes and nurses who were in a position to do so sometimes felt compelled to bring new perspectives to the table when discussing family planning options with women in their communities. A nurse at one clinic who grew up in the capital, Bamako, was keen to emphasise economic benefits of birth-spacing to women as well as men, and encouraged women who were permitted to work to find employment in order to better provide for their existing children:

If you wait you can work and look after your family and get a job. It is good for women to work. Some are not allowed to, but women should work to help their families. They will be able to help their children by paying for school and the clinic.

Particularly in smaller, more remote communities, it was common for matrones to extend their roles as health care providers and advisors into the area of relationship counselling where women were experiencing difficulties with their husbands. A matron at one more remote clinic said that she often had to 'talk between' husbands and wives, but that sometimes women take the wrong strategies with their husbands. She gave the example of a recent case where a woman came to the clinic for pre-natal care, and required a vitamin injection and a prescription for anti-malarials. She was not able to pay for this because her husband would not give her money for the clinic.

He also refused her money for the market, which meant she could not buy the fruit and vegetables she required during pregnancy. She confided in the matron that she intended to withhold sex from her husband in the hope that he would relent. The matron explained to her:

That is not good, you have to sleep with your husband because you already have a child to support, and you must protect them. You must maintain good relations in the family.

The matrone then spoke to the woman's husband herself, and explained that the money was needed in order to keep his wife healthy. As with many of the other matrones in the district, she emphasised the economic arguments, explaining that if his wife died, he would have to support his children alone. According to the matrone, families require this advice in order to make the right maternal health care decisions, and it is very important that women do feel able to talk to her about their family problems so that she can help. In addition to mediating between husbands and wives, matrones will sometimes agree to help women by hiding their clinic visits from their families. They do this by keeping their clinic cards (visit records and instructions) at the clinic instead of with the patient, therefore reducing the risk of it being seen by their families.

A further strategy employed by health care workers in order to extend maternal health care networks in their communities was by taking information about maternal health care and making it relevant in the delivery of other kinds of health care. A key example of this was the vaccination days held regularly by the clinics in which I worked. On these days mothers or female relatives such as grandmothers or older siblings would bring children in for their childhood immunisations, with groups of women gathered on benches outside the clinic. Matrones would sit at a table, administering vaccinations, weighing and measuring babies and recording their findings in clinic record books. The matrones explained to me that vaccination days presented an excellent opportunity to talk to women about nutrition, pre and post natal health care and family planning, in addition to discussing the health of their babies. As one matrone pointed out, 'talk is important'. She explained that particular attention should be paid to the mothers of new-borns, and said that matrones should make sure that they ask women how they are feeling in order to ascertain whether they were experiencing post-partum complications. If they suspected problems, the

matrones would refer the women to the CSCOM or the nearest hospital where possible.

Vaccination days were social occasions in the community, in which many women and their children would sit and talk together while they waited to be seen by the matrones. Women visiting with their children would also help the matrones with their work, or assist mothers with several young children by supervising them while others were being assessed by the matrones. Observing these days I noted that several women arrived at the vaccination post who were not scheduled to be there, some to enquire about vaccinations and others to seek advice regarding to family planning and pre-natal care. Those who enquired about pre-natal care were cordially received, and matrones were prepared to advise them of the procedure for pre-natal care while they were attending to children on vaccination days.

When conducting prenatal consultations, sages-femmes and matrones would often ask more general questions about women's well-being and family in addition to collecting clinical information in order to ascertain broader risk factors relating to women's pregnancies. They understood that women's economic and family situations as well as their personal experiences and beliefs would influence the likelihood of complications during pregnancy and birth. As such, they expanded the basic requirements of prenatal consultations which focused on clinical assessments to include conversations with women which would help them address the social and economic factors relevant to pregnancy.

During pre-natal consultations, health workers are required to record information about their patients including an estimate of how far along they are, and to check for symptoms which could indicate complications. They also collected blood in order to test for malaria, and conducted a physical examination. The atmosphere during the consultations was friendly and often jovial, with health workers enquiring how women are feeling, asking after their other children, their husbands and parents, and making jokes. In larger clinics there was often more than one staff member present during the consultation, with one (usually a sage-femme) leading discussions with the patient, one to take a blood sample and others to bring records where needed. Some matrones would join in general conversations during the consultation and come and leave as required, creating an active but welcoming environment.



Fig 16: Waiting to be seen at a CSCOM.

Photo by the author.

On occasion they would share a joke with the patient, a common source of entertainment being if the patient happened to share the same, or a related name to that of one of the health workers. This derives from a well-known Malian tradition referred to as ‘joking cousins’, whereby two people bearing a related surname are permitted to insult one another in a friendly manner, or to display a sense of familiarity. During a consultation in which the patient and several of the matrones shared related names, the sage-femme joked that the woman’s baby was related to all of them and they were all invested in its health and well-being. Conversations with women through the consultations provided health workers with opportunities to identify broader social issues, and give targeted advice regarding the pregnancy. They would enquire after their patient’s other children, ask whether any previous children had died, and ask about their use of contraception. Asking after women’s families, they would enquire as to her partner’s occupation and whether they currently lived together. In asking this, the health workers were able to ascertain the financial and social support system in place for women during their pregnancy and beyond.

It was sometimes the case that women, particularly where their husbands had multiple wives, that women would live with their parents in a different town to their husbands, or choose to go to their parents’ town for the delivery. The health workers were skilled at ascertaining this information through friendly conversation while they examined their patients, and would counsel as appropriate, ensuring that the women they treated understood how to manage the pregnancy and prepare for the delivery.

In one case, health workers conducted a consultation with a woman who revealed to them that she had not yet disclosed her pregnancy to her husband or family. She explained that she had a seven year old child to whom she had given birth when she was very young, and had since attempted to abstain from sex in order to avoid further pregnancies. The health workers discussed family planning options with her, and explained the preparations she would need to make in the coming months including healthy food for her to eat, and things she would need to buy in order to prepare for the birth.

Although all health workers conducting prenatal consultations would broaden their consultations to include conversations which would help them ascertain social or financial barriers to healthy pregnancy, there were marked differences between consultations at larger clinics such as Malibougou in the town of Kati, and the smaller, more rural clinics in which I worked. The clinic at Kati had a larger staff of matrones, who would assist the sage-femme during consultations and engage in group conversations with patients and colleagues throughout the day. The staff were friendly and welcoming, but consultations were in no way private, and health workers would enter and exit the room at regular intervals. During discussions about their conduct during consultations, the sage-femme explained that while she was aware that things are done differently in England, here it was up to her what happened during the consultations. Health workers at Malibougou were generally keen to assert that they were in charge of what happened during their consultations with patients, and although they acquiesced to my request that consent be obtained from each patient before I observed a pre-natal consultation, they expressed a belief that decisions regarding consultations occurring in the clinic should be entirely their domain.

In contrast, the attitude of the sages-femme towards confidentiality in smaller, rural clinics reflected a different understanding of the health worker-patient relationship. In one case although the médecin chef had instructed the sage-femme that I was to be admitted to all her pre-natal consultations for the day, she explained to me that consultations were private, that I could only stay for the initial discussion, and only then with the patients' consent. The trust of the community which the sage-femme prized so highly in her daily life in the village was a principle which she maintained in the running of the clinic, emphasising to patients (and visiting researchers) that patient confidentiality was of the utmost importance. When describing her discussions with

women in the clinic about pregnancy and family planning, she would often begin by saying 'I close the door', indicating to her patients that their conversation would remain between the two of them. The more well-known sages-femmes and matrones are in their communities, the more likely it is that they rely on the notions of 'la confiance' that accompanies their role, and the more likely they are to observe the obligation of confidentiality which accompanies their profession.

Although matrones and sages-femmes in all clinics often took the opportunity to discuss the broader social issues which could impact their patients' pregnancies, stricter observance of physician-patient confidentiality generally created a more fruitful environment in which to do so. Health workers in smaller, more rural clinics were also aided in their efforts to discuss wider issues by having more specific knowledge of their patients, communities, and the specific issues which they were likely face. The sage-femme whose consultations I observed in a rural clinic was particularly observant of aspects of the lives of women living in her community which could pose hazardous during pregnancy. She used her discussions during pre-natal consultations to ascertain potential difficulties, and took the opportunity to educate when appropriate.

During one consultation, she asked her patient how many babies she had given birth to, and asked whether any of them had died. Her patient replied that she had given birth to four babies but two of them had died. After hearing this, the sage-femme said she was sorry, and gently asked what had happened to the babies. Her patient replied that they had been ill, and the sage-femme asked how they had been treated. She learned that the family had taken them to a traditional healer, which had not been successful. The sage-femme then explained to the patient that if she or her children were ill, she would like them to come and see her instead of the traditional healer. She emphasised that now the patient was having another child, she should use a different strategy to look after the new baby:

Please do not do that again. If your new baby is ill, please do come to see me at the CSCOM and I will help you.

The sage-femme would ask women to tell her their previous experiences of pregnancy and delivery, and would listen patiently to their stories, picking up on aspects which needed to be addressed to improve the safety of the pregnancy and delivery on that

occasion. She would also note if women had not come to see her at appropriate points during their pregnancy, and attempt to ascertain the barriers to them seeking pre-natal care. During one consultation, the sage-femme noted that her patient was several months pregnant and had not come to see her. She asked why, and was told that the woman's husband had refused to supply her with money for the clinic.

The woman's story was familiar to her; she was pregnant with her fourth child, had sought medical care from the clinic for her first child, but the child had died. She had needed a caesarean, which were not available at the small clinic in Diago. She had slept at the CSCOM the night of her labour, and was taken to Bamako (some 40km away) in the morning, by which time the baby had died. The sage-femme emphasised the importance of coming to see her regularly during pregnancy so that she could predict if there were going to be complications, and prepare for them. She then checked that the woman had a mosquito net to sleep under to prevent malaria during pregnancy, and shared a joke with her, which had the effect of ending the consultation on a positive note: The sage-femme liked the patient's dress, and joked that, given that she was the same size as her pregnant patient, her patient could give her the dress after she had given birth.

In addition to ascertaining details regarding previous births, contraception, traditional healers and family support system, the sage-femme and matrones at this clinic would also take the opportunity to address the subject of abortion. They understood that although abortion is illegal in Mali apart from under exceptional circumstances, traditional healers operating in the area were prepared to offer women a preparation which was designed to terminate their pregnancy. This was a particular concern for the health workers at the clinic as it posed significant risk to the lives of women who sought to terminate pregnancies. The sage-femme and matrones at would respectfully ask women whether they had attempted a termination, had completed a termination in the past, or whether they were considering the option. They would explain that everything that was said was private, and that the patient could trust them. They explained that the reason they were asking was because doing this greatly increased the chances of complications, and they wanted to know so that they could help. A matron at the clinic explained to me:

We ask all the women about abortion, it is important that they know that they can die if they do not say. They will talk to us because they know they can trust us. We should make sure that women know – if they come in for vaccinations you warn about termination, and tell them they could die.

Network ‘failures’ and limitations

Throughout my time observing the activities of health workers in the district of Kati, it became apparent that the majority of *médecins chefs*, *sages-femmes*, nurses and *matrones* developed numerous strategies for promoting maternal and reproductive health care amongst the communities in which they worked. Yet I also had the opportunity to observe the limits of their capabilities, and the various challenges which prevented them from connecting with community members on matters of maternal and reproductive health care. I found that the different ways in which these failures manifested and were experienced by health workers shed significant light on the factors affecting the uptake of these services. These factors were multiple, including the decline of community integration in areas of rapid population expansion, limitations imposed by the legal and social position of women, and lack of resources to support health workers’ efforts to make connections with the communities in which they worked.

The following account from the largest clinic in which I worked demonstrates the failure of the maternal health care network to reproduce due to the limits imposed by the rapidly growing population and concurring change in the nature of community relationships. Malibougou was the largest clinic I visited, and was one of several community clinics located on the edge of the town of Kati. Like the other health workers in the district, those based at Malibougou emphasised the importance of taking as many opportunities as possible to educate women about maternal health care, and espoused their willingness to make themselves available to those in the surrounding area for help outside of clinic hours. As one *matron* explained:

We do vaccinations days, there are many women who come to us with their babies... before we do vaccinations we talk about what you have to do with your baby or if they woman is pregnant we talk about what they have to do. We talk about this first and then we do vaccinations. We talk about how to protect against malaria if they are pregnant, and talk to them about planning.

However, it became apparent that in practice health workers at this clinic had few opportunities outside settings such as pre-natal consultations to advise women on these matters, and were often reluctant to expand their advice beyond that which was specifically required by their role. Observing a vaccination day here, I noted that most matrones were not taking the opportunity to speak with mothers about maternal and reproductive health care, despite the ubiquitous assertion that vaccination days were ideal opportunities to impart such advice. The matrones appeared rushed, and usually only spoke at any length to women who had failed to bring their child to the clinic for a previously scheduled vaccination, or whose children were showing signs of malnourishment.

After the vaccination session was done, an experienced matron who had come in to help for the day expressed dismay to her colleagues that they had not enquired about mothers' family planning or warned about the dangers of attempting to terminate a pregnancy. Her particular concern was that mothers should be reminded to come to all their pre-natal visits and warned about the dangers associated with self-administered abortion for mothers during current and future pregnancies. This, she said, can lead to serious complications in subsequent pregnancies, and having lots of women of child bearing age together was an excellent opportunity to get this message across. The other matrones responded that they had not had the time because there were too many people coming in at once. This was in part due to the fact that a date for vaccinations is announced in the community, but no appointment times are made.

In many areas it is unlikely that women will be able to attend an appointment at a specific time due to their other commitments, and women living in rural areas did not usually keep 24hr clock time. Where appointments were made, they were more general and based on morning or afternoon, or in areas where *Adhan* was announced, based on prayer times. In addition to reminding people when they are at the clinic that they will need to come back on a certain day, the clinic staff also announced which days the clinic would be seeing people for vaccinations and allowed the message to spread by word of mouth. This was an unreliable method, meaning that many women and children did not come when they are due, and others came when they were not expected. Several of the women who visited with their children on Malibougou's clinic days were not due to bring them to receive a vaccine, either because their babies had received it already or because they were not yet at the right age. They had heard

by word of mouth that they should bring their children to the clinic on this day, and added to the considerable numbers of people waiting to be seen by the matrones.

The town of Kati lies about 15km from the capital, and the area surrounding the town was rapidly expanding. As a result of population growth in the area, the staff at Malibougou were seeing far more patients than other clinics in more rural areas of the district. As the matrones explained, the large numbers they had to see on each vaccination day made it difficult for them to take the time to discuss maternal and reproductive health care with women.

The consequences of a rapidly expanding township extended beyond placing limitations on the matrones' time and resources. A further issue pointed out by the matrones was that as the town grew, people knew each other less well and were less likely to engage in personal discussions with health workers. This meant that health workers did not always feel that it was appropriate to discuss family planning or abortion outside of the context in which it was required. They were also concerned that if they did involve themselves in disputes between husbands and wives or daughters regarding family planning or use of the clinic, they would incur the anger of men in the district. One of the matrones at Malibougou explained that she saw her role primarily as providing a clinical service, and said she doesn't want to talk about people's personal lives:

A while ago people used to come here to talk about their families and their problems, but not so much now. Now they don't want to explain their problems...they come for help having a baby and for family planning, and I do just that. I don't want to talk about problems. I don't want problems with husbands.

During group discussions, the matrones at Malibougou related their fears regarding being trusted with women's secrets, and dealing with situations in which women's husbands refuse to allow them to use the clinic for family planning or pre-natal care. On the one hand, they did not now know many of the women who came to the clinic, and did not feel comfortable intervening with their spouses. On the other hand, they were also concerned that if women needed help and they did not provide it because of the wishes of her husband, they would be held responsible should she die:

Today it is dangerous to tell your secrets here. Women do not always trust us with secrets. It is not easy to talk about problems and we can't talk to everyone we see about this. Sometimes husbands don't want their wives to do planning. We can call the husband to explain, but if he says no, we tell him to take his wife to another clinic. It cannot be our fault if she dies. We don't want problems with men.

Conversations with the matrones at Malibougou opened up some critical perspectives on their understandings of women's rights and position within the southern Malian society in which they lived. In many of their interactions with woman in their capacity as health care workers, the matrones came back to the fact that there were limited options both for them and for their patients while women had no power to make decisions about their fertility. Discussing the factors preventing women from accessing reproductive health care, one of the matrones explained:

Women have no rights. Men have rights but not women. Women's rights are in the home.

Discussing this issue in a group setting, the matrones and sage-femme at Malibougou agreed that while they should do what they can for their patients, there was only so much they could manage – men have the final say in Mali. I observed that the sage-femme was wearing a *pagne* (wrap-around wax cloth) bearing the slogan of international women's day, a national holiday in Mali, and she explained what it meant to her:

It is a national holiday for women. It's a time when men should cook for women and look after the children, but they never do! Women's rights in Mali means 'what it is right that a woman should do'. Women look after the house and their husband and children

One of the matrones added to this:

"This is how it is. If you want to work, but your husband doesn't want this, you put your CV back in your bag."

I asked them what they thought about the slogan on the sage-femme's *pagne* which advocated women's right to work. Discussing this further, they agreed that these kinds of rights mean getting involved in politics, which is not something they wanted to do:

Doing that means you have to lie. It means a fight.



Fig 17: Woman selling garlic, Mali.

Photo by the author.

The experience of the health workers at Malibougou demonstrated that a fast-growing, dense population had the effect of weakening community relationships, and left the matrones feeling unable to discuss elements such as family planning, finance and relationships which impact maternal health care with women with whom they were not well acquainted. In more rural areas in which clinics served a smaller but more scattered population, health workers also struggled to maintain their connections with community members. Although they were well-known and experienced great successes in advocating clinic services in the area surrounding the clinic, due to the diffuse nature of the population, they were only able to access a small proportion of the communities that the clinic was required to serve.

As previously discussed, the *médecins chefs* in these areas were equipped with motorbikes and made efforts to visit with village chiefs as often as they could in order to maintain relationships between their clinics and the communities they served. For the *médecin chef* at Dio Gare, this was particularly important due to the political history between the neighbouring villages and the clinic. Yet without formal support for the majority of his community networking activities, the *médecin chef* found that his opportunities for extending these networks further in the region were limited due to lack of resources and infrastructure. Having his own transport, he was able to visit the villages which lay nearby the clinic, but was unable to make regular contact with

villages further away and still maintain his duties at the clinic. Travel to these areas was difficult both in terms of the time it would take him to reach them, and the fact that there were no roads connecting the villages to the clinic, making traveling long distances on the bike hazardous.

The task of advocating clinic services in the communities served by the CSCOMS officially lay with the relais, although formal support for them was sporadic and ill-defined. Each village selects two volunteers to take on the position of relais, a decision which is made by popular opinion and endorsed by the village chief. Being resident in the communities which they serve makes relais an accessible link to the health service, and it is generally known that they can be approached for information on health care and the clinic. Where they can, they also conduct talks and advocacy work, reporting either to their local CSCOM or to an NGO assigned to their training.

However, there is no remuneration for the work that they do, and the relais generally have permanent jobs in their communities which take up the majority of their time. Officially, the health service supplies relais with what is referred to as 'motivation' in the form of small cash incentives or equipment such as bicycles to aid in their community work, yet these donations are sporadic and cannot be relied upon. As such, it is not always possible for relais to maintain a working relationship with clinic staff, especially if they represent villages located far from the CSCOM. Taking time off from their paid work is often not an option for them, which can make it difficult to find people willing to act as relais. As one village relais explained:

We are allowed to be a relais while we have a job, the boss allows this. But we do not get paid when we are not at work so it is difficult. Sometimes it is difficult to find people to be a relais because of this.

Where relais training is conducted by CSCOMs, villages are sometimes unable to send relais to attend training at the necessary times. In some cases, NGOs such as UNICEF and CARE visit villages in order to provide training for relais, but again this arrangement is sporadic and reliant on necessary funding. In addition to financial and transport issues, the lack of communication between the health administration and rural communities sometimes led to the implementation of schemes which were unsuccessful. For example, I learnt of a health service scheme in the district of Kati to provide the relais in one area with bicycles to make their traveling to CSCOMs more

efficient. When the relais arrived to collect them, many of them turned up on their mopeds, an event which underlined the need for better communication and further investigation into the limitations faced by relais.

Health workers posted at CSCOMs in the district were generally very supportive of the idea of relais as clinic representatives in the communities served by the clinics, and welcomed the opportunity to further the advocacy work that many had taken on as part of their role as a health care provider. They felt that having members of each village take on this role was effective, because they were on hand to advise community members where sage-femmes and matrones were not. They also noted the importance of being well-known and trusted in their communities, and understood that relais were in a good position to build this trust and advocate clinic services. Yet they were also aware of the limitations to the services which the relais were currently able to provide, and many of the health workers expressed concern that the relais would not be able to perform as they should if they continued to receive so little support. The matrones in all clinics emphasised the importance of using relais to spread the word about safe practices during pregnancy and the importance of pre-natal visits. As one Matrone said:

The relais are very important. They explain to people how to use the [mosquito] net and to take malaria tablets when they are pregnant, and that they need to come to the CSCOM for planning and pre-natal visit. They do good work in the villages and should be paid for this.

Having little contact or influence with the health authority, médecins chefs in the area approached this issue with villages authorities, but were unsuccessful. As one clinic chief explained:

The relais are vital but they are not paid. They don't get 'motivation' here. We tried to persuade villages to help pay them but they will not give. So we treat them, their wives and children for free.

Theoretical reflections

The ethnographic examples I have explored here reveal a community health system characterised by a high level of health worker innovation. Although their activities are limited by the health service and the conditions in which they work, in as far as they are able many health workers adopt strategies which help improve health care

relationships for women in their communities. In the final part of this chapter I discuss the themes which have emerged from examining the activities of health workers, including their informal networking capacities, notions of trust and obligation which define health worker roles, and the limitations and failures of health worker activities which I view as artefacts of the health systems in which they work.

Informal networks for improving maternal health

A considerable amount of health education and advocacy, particularly with regards to women's reproductive and maternal health, is performed by government health workers who have developed their own informal strategies for generating positive health care networks in their communities. In many of the cases discussed here, health workers involved themselves in the project of recruiting community members by finding innovative ways to advocate the maternal and reproductive health services offered by the clinic. As Mosse and Lewis (2006) have stated, one of the key principles of creating a successful network is the ability to recruit others into it in order to further the purpose of the network. These strategies were employed by many different health workers with different levels of training and experience, each using the resources available to them.

Médecins chefs emphasised the importance of connecting with village chiefs in order to persuade them to advocate the clinic, and intervene where men were preventing access to the clinic for their wives and daughters. They understood that village chiefs command much respect, and are more likely to be effective advocates than clinic staff where village men have doubts about the clinic. By paying their respects regularly to them, the Médecins chefs created a system in the villages surrounding each clinic where they could advise the chiefs of cases where women were in need of maternal health care which they were not receiving due to family problems. By educating the chiefs about the need to allow women to use contraception, they were able to use them as advocates for maternal and reproductive health care alongside the village relais.

As educated men and the heads of clinics, Médecins chefs also commanded respect themselves, and were able to take their understandings of local communities and connect this with their roles as maternal health care advocates. In this way they put

different kinds of information into practice together, strengthening the links between communities and the clinic. Latour's concept of "composition" is particularly useful here; what we are viewing is not the product of a coherent health service policy, or the enactment of roles pre-determined by an existing social structure that we might discover, rather these actors are engaged in daily processes of putting their ideas and understandings together, and recruiting actors, whether they are their patients, patient's families, or community figures, into their plans (2000).

In so doing, health workers demonstrated a marked capacity to "translate" their messages in ways appropriate to their different audiences, in order to further their work of "generating interest" in their approach to women's health (Latour, 1996:33). The nurse who described counselling a woman after her husband demanded her implant be removed provides a clear example of this translation technique, which she not only employs herself but also teaches women to employ with their husbands. Like most of the health care workers I interviewed, she will go out of her way to talk to husbands about allowing their wives to use clinic services, whether it is coming in for a prenatal visit, vaccination, or to do family planning.

Further to this, she has constructed an effective means via which to recruit men who are reluctant, by advising their wives when and how to talk to them about the issue. Her understanding of the fears surrounding the clinic, coupled with her understanding of relationships between husbands and wives in her community, meant that she was able to give productive advice as to how to persuade husbands of the value of the clinic. In so doing, she demonstrated her ability to engage with the different informational practices that are enacted in village relationships. Health workers generally agreed that focussing on economic interests was a productive way to advocate clinic services to men, whilst discussing the health of children and their own health was more effective for women.

In addition to translating their messages in order to recruit community members, health workers also extended the reach of the health care networks they had generated, taking their advocacy work beyond the clinics in which they were posted. By engaging with community members outside of the clinic, health care workers extend the trajectory of their networks beyond the clinic and into family homes and market places, and in so doing open up new opportunities to reach people. In this

way, health care workers are enacting possibilities that go far beyond government conceptualisation of community clinics as medical service providers. They understand that changing views of the clinic and providing maternal health care information has to happen in communities, and change cannot be effected simply from within the walls of the clinic. In the communities in which I worked, power over household income and health care decisions lie with men, making it a vital task to extend the reach of the maternal health care network from clinics into the villages.

A further way in which health care workers changed the morphology of the maternal health care networks was by taking information about maternal health care and making it relevant in the delivery of all kinds of health care. Vaccination days were seen as opportunities to talk with mothers and female relatives about nutrition, pre and postnatal health care and family planning, in addition to discussing the health of their babies. Prenatal consultations were used as opportunities not just to talk about managing pregnancy and delivery, but also the need for contraception later on. Health workers would also use these consultations as opportunities to discuss the dangers of attempting to terminate pregnancies, their patients' previous deliveries, and family situations in order to assess potential dangers and the kind of advice that they should be giving.

If the network 'nodes' are sparse beyond the clinic, the fewer chances health care workers have of changing attitudes and beliefs surrounding maternal health care. If they can change the morphology of the network to include nodes in the villages, such as a matrone who is willing to talk to village women in her everyday life, or a village chief who will explain the importance of men allowing their wives to use the clinic, the more opportunities there are to extend the reach and strength of maternal health care networks.

Through the work of extending their reach and "translating" their ideas to make their advocacy work more effective, health workers were harnessing the potential of health care networks to reorganise power relations such that women were able to exercise greater control over their lives and bodies. Here is an example of Castells's point that changing network morphology can lead to considerable shift in power relations (1996). There is an important lesson to be drawn from the cases discussed here. These are communities in which poverty is widespread, and in which women have very little

control over their own lives. Yet through their own largely informal strategies, health workers were regularly able to challenge dominant knowledges and open up new health care opportunities for women.

An instructive point to raise here is that health workers did not think of their advocacy work in communities or the services they provided at home as ‘informal’ or secondary, rather they maintained that although this work was not part of their official mandate, it was a key part of the role of being a health worker in their communities. Notions of trust and obligation were common themes, and for many roles were defined on the basis of the understandings, needs and demands of their communities rather than through their official mandate. Offering advice and receiving patients at their own homes was part of what it meant to be a community health worker, and a trusted figure. In rural areas, health workers’ often felt empowered by the esteem in which they were held by their community, a fact which furthered their desire to help in any way they could. Discussing community health worker incentives, Bhattacharyya et al (2001) note that ‘trust, prestige, mobility and social interaction’ are factors which incentivise health workers. These factors are particularly significant in rural communities in Mali, where community health work is one of the few means for women to achieve sustained employment, and to gain prestige and respect in their communities.

Network failures

The level of health worker innovation discussed here is a remarkable artefact, and one which underscores the potential of community health workers to improve understanding and uptake of maternal and reproductive health services in their communities. Yet some of the most instructive cases I have discussed were those in which health workers failed to perform this aspect, and those in which their efforts were limited. These cases illustrate the challenges faced by health workers, and in so doing indicate the particular conditions under which the social side of maternal and reproductive health provision fails to thrive.

A principal problem faced by all health workers in extending their health care networks derived from the topologies with which they had to work. Health workers serving small, scattered communities were able to harness existing, close-knit

community relationships, but struggled to extend their networks far beyond their clinics due to the remoteness of many of the communities, and poor transport links. In contrast, health workers based at the larger clinic in the town had greater access to the population and more resources, but were often unable to make positive health care connections due to a diverse and quickly expanding population amongst whom connections, relationships, and trust were weaker. The rapidly expanding population also generated greater demands on health workers' time, meaning that they were more likely to stick to the provision of basic services. As Cattell reminds us in her work on health care networks, 'network typologies...are concerned with communities of place, time and structure, as well as the members of those communities on whose experiences and perceptions they are founded' (2001:1506).

A further factor which limited the efficacy of health care workers' attempts to extend their maternal and reproductive health care networks was the social position of women in the communities in which they worked. Although women have equal rights under the law, the reality for many women is that they have very little control over resources and health care decisions. In the majority of households served by the clinics in which I worked, men have control of household finances, meaning that many women – especially those were not in paid employment – could only pay for medical care with their permission. Common perceptions of family planning include the view that it enables women to be promiscuous, and also the belief that it renders them infertile, a circumstance which is looked upon gravely in a society in which having many children is seen as a blessing and a sign of prestige. A further concern, especially in rural communities, was that the money used to pay for clinic services would line the pockets of corrupt doctors.

Health workers developed many strategies to combat these perceptions, including visiting women's husbands and families in order to advocate clinic services, and treating women for free and in secret. Yet in cases where their efforts failed, health workers had no further means through which to help women in their communities who wanted to use family planning, or to visit the clinic for pre-natal care and delivery. 'Problems with husbands' was a recurring theme amongst health workers, who often expressed frustration that there was little more that they could do once a husband has said no. The position of health workers as women in society should also be noted, as they themselves were subject to the limitations of their gender when

approaching men in order to discuss health care issues. Several health workers expressed a reluctance to discuss ‘family matters’ with husbands, and others said that they would not push the issue, wanting to avoid problems with husbands.

Integrating the social side of maternal health care

Overall, whilst almost all health workers emphasised the importance of talking with women in their communities about family planning, prenatal care and delivery, the health system offered limited means via which they could perform this side of health care. This is a community health system in which the formal integration of social initiatives to improve maternal and reproductive health care is marginal. The Ministry of Health is highly reliant on the activities of the unpaid, part-time relais to increase reproductive, maternal and child health education and advocacy in rural communities, and both donor and NGO partners have been working to improve the training and coverage of the relais on the basis that community outreach is highly effective in improving uptake of maternal and child health services (cf. CARE, 2009, USAID, 2013). Yet with as little as five days training, lack of sustained support and no salary, relais’ capacity to advocate clinic services and perform health education is extremely limited.

Health workers in rural communities expressed a desire to be able to be more available to see people outside of the clinic, saying that they were not often able to see women at their houses because of the time they spent working in the clinic. One médecin chef said that he wished that he could keep the clinic staffed for longer hours, and there were facilities at the clinic for staff to be able to sleep so that they would be more available to community members.

The views of health care workers of their own roles are perhaps the most instructive with regards to integrating the social and clinical sides of community maternal health care. They emphasised that talking with women and their families in order to educate and advocate was one of the principal means to improve maternal health in their communities. Further, they did not view any of their strategies as secondary to their clinical role, or as informal. Rather, they understood the role of community health worker to involve both clinical and advocacy work, and found ways to bolster the latter where they felt it was lacking. The patterns generated by both their strategies

and failures are peculiar to the material conditions in which they are attempting to further maternal and reproductive health care, and indicate the gaps in a system which limits their capacity for advocacy work.

In the next chapter I turn to a different kind of community health system, in which health workers are required to perform a great deal of community outreach work in addition to their clinical duties.

Chapter 7: Ghana ethnography

The purpose of this chapter is to provide ethnographic evidence which demonstrates the relationships and interests which emerge where community maternal and reproductive health care networks are formalised by the Ghana health service, which sought to combine the provision of community and clinical health care services. The data discussed here was collected during my fieldwork carried out in the Shai-Osudoku district of Ghana, an area in which the health service's CHPS system was being rolled-out and monitored. The project was in its infancy in this district, having been implemented in some areas two years prior, and in others as little as six months ago, making it an excellent location in which to examine the particular maternal health care patterns and relationships which emerge when community health care is formalised and delivered alongside clinical services.

In what follows, I discuss the implementation of the CHPS system in the district and examine the way in which community health care workers conduct their dual roles as clinicians and community health officers. The chapter demonstrates the regulations and requirements which structure the provision of CHPS health care, and describes the difficulties encountered by health care workers attempting to adhere to these requirements whilst both generating community health care relationships and providing clinical care. It then describes the informal practices and coping-strategies developed by health care workers who find that they are often unable to meet the requirements of the CHPS programme in practice due to lack of information and resources, and reluctance on the part of their communities to comply.

I view these strategies as brokerages of the kind proposed by Bierschenk et al (2000), which in this case involve health care workers collaborating to circumvent the requirements regarding home visits and outreach programmes in the community, actions which are contrary to the key objective of the CHPS programme to improve health care by forging and maintaining positive health care relationships with clients in their own communities. The ethnographic examples discussed below illustrate the uneasy relationship between clinical and social care as it has been formulated within the CHPS policy, and demonstrate that health workers' coping strategies have a particularly negative impact on the provision and uptake of maternal health care

education and services, where home-visiting and positive community-health service relations are crucial. However, there is also evidence that the strategies employed by some health care workers which run contrary to the CHPS mandate have aided the provision and uptake of maternal health care services, particularly in areas where health workers have been able to build greater understanding and trust in the communities in which they work.

Implementing CHPS in Shai-Osudoku

During my research I worked in four CHPS zones in the region, two with fully functional government-funded CHPS compounds, one with an as yet unaccredited, part NGO-funded CHPS compound, and one in which two newly-trained CHPS officers had been moved to the area six months previously to begin the process of CHPS implementation. My time was spent observing the daily practices of health care workers in clinic compounds, conducting interviews with CHOs, midwives, and community health care volunteers, and accompanying CHOs on village outreach programmes and home visits. Additionally, I assisted in the clinic and on outreach programmes by dispensing vitamins, weighing children and assisting with clinic record keeping.

Two of the clinics in which I worked were well established, and had been up and running for four years. Each was staffed by a midwife who was in charge of the clinic compound and managed the staff who lived and worked there. The clinics had three CHOs whose principal role was to conduct home visits and community outreach programmes, and with whom I worked closely during my time in Shai-Osudoku. Additionally, the clinics were also staffed by an enrolled nurse, whose role it was to remain at the compound and treat emergent cases as they arrived. The CHOs had completed their two year community health care training courses, but were keen to point out that they had much training still to come, especially in the area of maternal health care and deliveries, where they were currently only qualified to assist midwives with routine deliveries. “We train on the job” they told me, and emphasised that they learn from more senior colleagues on a case by case basis. Most of the CHOs with whom I worked were relatively inexperienced, and their current posts were the first they had been assigned out of community health school. The majority of the CHOs in the district were young, aged between 20 and 25, and were unmarried. However,

several of the CHOs had young children who lived with them in the clinic compound in cases where the CHOs lived-in.



Fig 18: Entrance to a CHPS compound, Ghana.

Photo by the author.

Living and taking meals in the CHPS compound allowed CHOs the opportunity to discuss any issues they had, and to ask questions of the midwives, who were permanently based at the clinics and had many years' experience. When the CHOs and midwives were not with patients or out on visits, they were often to be found sitting together in the middle, open-plan section of the compound completing the insurance paper-work which needed to be submitted for each of the clients they had seen. Rather than sit in the separate rooms in the compound, the staff, including the midwives, often chose to move a table and chairs into the communal area and sit together to complete their work and chat as they did so.

The clinic compounds themselves had become households, in which staff often cooked and ate together, and looked after one another's children should a CHO go out on a visit or into the town on an errand. As is the practice in Ghana, young children are carried in slings about women's hips, and it was not uncommon for CHOs to carry one another's children as they went about their work in their compounds, including during consultations with patients. In one compound in which

I worked, the midwife in charge of the clinic was considerably older than the CHOs and was treated as a maternal figure by the staff, who called her ‘auntie’. She was well respected, gentle and good humoured, and it became apparent that the CHOs sought her advice both on professional and personal issues. The CHOs explained the importance of creating an atmosphere in which community members felt comfortable talking to them and visiting the compound:

Not imposing ideas is very important. You must help clients to make their own choice. If they don't feel comfortable, they won't come back if they have a problem.

As many people living and working in CHPS zones commented, the appeal of the CHPS system for both CHOs and many community members was that the lines between the health service and the community, medical and social service provision were broken down by the fact of having CHOs become part of the community. The CHOs played out a great deal of their lives in the local market and clinic compounds under the supervision of their peers and the midwives, which created a local support system and grounded them in the community. They were also presented with a new idiom with which to understand their roles in the community and the people to whom they provided CHPS services. Community members were to be known as ‘clients’ rather than patients, and thought of as customers and acquaintances rather than sick, powerless figures. As one of the CHOs explained to me:

We call them clients because they are not sick. We need to make them feel comfortable – they come in for a service so they are our clients.

In the two well established compounds, the CHOs had settled into their zones, and were generally well known amongst the communities they served. They served a population of about 3,500, spread over 12 villages. I accompanied the CHOs on their home visits and outreach clinics in their communities, and on every visit they were approached on numerous occasions by community members wanting to greet them and ask questions related to health or community outreach events. One of the CHPS programme goals is to provide CHPS officers with bicycles or motorbikes, but none of the CHOs with whom I worked had regular access to transportation to the villages. Where they were unable to hitch a lift with a member of staff passing from the town, they walked, sometimes several miles, to reach the villages on their rotas.



Fig 19: Child welfare day at a clinic, Ghana.

Photo by the author.

Their distinctive brown and green uniforms, and the fact that they often had to walk through their communities on foot, made them very visible to those who sought the opportunity to ask their advice as they passed. As I have previously discussed, the CHPS notion of relocating health care workers to remote areas to live and work in their communities was intended to allow informal, as well as formal contact between community members and health care providers. Living in their communities meant that health workers could be approached at any time by those with questions or ailments, and this led to several CHOs expressing a feeling that they were always ‘on-duty’. As one CHO commented, ‘when they see you in town they say “why haven’t you come to my house?” Even when you are busy or even asleep! “I have a problem.”’

Many of the questions with which CHOs were presented when walking through the communities in their CHPS zones were related to contraception, a common issue being that many women were unsure when they should next visit the clinic to renew their contraceptive injection. The CHOs would make a note to check the date it would be required, and assure them that they would visit them beforehand to let them know when to come to the compound. Women who had recently begun using

hormonal contraception and were experiencing side-effects would also approach them for advice, where upon the CHOs would reassure them and refer them to the clinic where they felt it was necessary. The CHOs were also viewed by many people as authority figures, and were asked about developments and events in the community such as the day an NGO cohort were due to arrive to conduct a health outreach programme, or to enquire as to why some villages had recently received a visit from aid workers and others had not.

Accompanying CHOs on their home visits provided insights into the potential of installing community health workers who were trained to talk to community members in their households to positively impact maternal and reproductive health care outcomes by building relationships with community members. In many cases, when the CHOs arrived at the households on their register they were greeted warmly, and offered stools on which to sit whilst conducting their assessments. When embarking on home visits, CHOs took home visiting kits which included a large register in which the health and demographic records of each household in their zone were recorded. At every household they visited, the CHOs would begin by ascertaining the data required by their visit books, principally the number of children under five years old living in the household, the number of pregnant women, and if there had been any deaths. Where women were pregnant or had recently given birth, the visiting book contained a section for the CHOs to record blood pressure, temperature, and notes on uterine contraction.



Fig 20: The delivery room at a clinic compound, Ghana.

Photo by the author.

At each household CHO's would proceed based on the information they had about the household, and what they found when they arrived. If there were women in the household of child bearing age, they would ask whether they had explored contraceptive options, and counsel them about the importance of birth-spacing to ensure the health of the mother and her children. Where women were already using contraception, the visit provided them with an opportunity to share any concerns, and receive information on when they needed to renew in cases where women were receiving the contraceptive injection. Where they found that women were pregnant, they recorded this, discussed the importance of antenatal care and attempted to arrange for the woman in question to visit them at the clinic. Both the CHPS advocates at a regional level and CHO's themselves often stated that a great advantage to home visiting was that the CHO's could provide counselling based on any issues that they detected when visiting households in person. As one CHO said:

We can counsel based on what we see. We ask women about previous births. If the children are underweight she may have too many. Sometimes the mother is carrying a baby on her back and she is pregnant with another one. Then we know.

The CHOs' visiting books also contain basic notes regarding each client's health records where visits have previously been conducted, and CHOs are often able to check the book and inform women when their next clinic visit is due. This is particularly important in Shai-Osudoku where the majority of the population are illiterate. This is illustrated by one home visit in which a woman asked to be told when she needed to return to the clinic to renew her contraception because she was unable to read the appointment card that she had been given. She reminded the CHO jokingly that she had been compelled to ask her this the last time she visited. The CHO reassured her that she was not yet due to come to the clinic, and promised to come by the house and tell her when it was due.

A second example of the efficacy of training CHOs to counsel community members in addition to providing clinical services can be illustrated with an account of a home visit conducted by a CHO based at a well-established compound. The household in question was the home of a traditional healer, his wife, and ten children, who all came out to greet the CHO, some of the older children playing 'Tag' around her back. The house was *Adanesi* mud brick, but large and ornate in comparison with others in the area. It was decorated with shells, and at the front a shrine was arranged with stones in a bowl, over which hung a red rope threaded with large African Snail shells.

After greetings were exchanged, the CHO instructed husband and wife to fetch their child welfare booklet, in which medical notes and the weight of children under 5 years old had been recorded. The CHOs do not often find that men are at home during their visits in the daytime, the majority of men being farmers or fishermen in the Shai-Osudoku district and away from dawn till night. In this case the traditional healer often worked from his home in the village, and took charge of the conversation with the CHO, answering each of her questions whilst his wife stood silently. Although she had visited his wife and children the house before, the CHO had not met the traditional healer until this visit. She asked him about his role as a healer in the community, and he explained that his principal role was as a herbalist, making preparations to treat a variety of ailments and problems. The CHO went on to ask him whether he received any support from the Ghana Health Service, and he replied that he had received training at the district hospital as to how to recognise emergent cases which would require a referral to a clinic or hospital.

After a friendly discussion about how traditional healers can work together with health service personnel, the CHO shifted the conversation to the couple's children, several of whom were playing in the vicinity of the house. The CHO learned that the couple had 10 children, and an 11th who had died. She asked whether they had tried family planning, and the traditional healer replied that although he had no principle objection to 'the injectables', he preferred his wife to use a traditional herbal remedy which he prepared himself. She asked him whether he thought this method was effective, and whether his wife had conceived since using the method. He replied that it was effective, after which the CHO said she was very interested in learning more about his work, and asked if she could come back to talk with him more about the preparation he used for contraceptive purposes. They agreed that she would return to find out more about his methods, and that she in turn would talk with him and his wife about the forms of contraception available from the clinic and how they would work.

After leaving the house of the traditional healer and his family, the CHO explained to me that although his wife and children were clearly at risk due to the high number of births, she would need to build a good relationship with them – particularly the traditional healer who made the medical decisions for his wife and children – before she could begin to advocate use of modern contraceptives:

This is the first time that I have met him, I must talk with him more. You cannot push your ideas, it must happen more slowly. Also he knows our methods, we must do more than tell him what is available. I cannot tell him he has to stop, it has to be gradual. I have to visit him again, get to know him and know how to approach him on the issue. I have to know how to talk to him in a way not to offend him. I will test his knowledge of our methods. I will talk to him and see if he will reconsider trying ours.

In this case, the CHO demonstrated a considerable understanding of her community, and the best approach to take in order to begin to change attitudes towards contraception and birth-spacing. She took time to engage in conversation about the importance of traditional healers and the health service working together, demonstrating that she had respect for the alternative medicine which he practiced. When she learned that whilst using a herbal contraceptive preparation his wife had given birth to 11 children, one of whom had died, she did not react by telling him that they needed to begin using modern contraceptives. Rather, she expressed an interest

in his work as a herbalist, and arranged to return so that they could each learn from the other the different methods of contraception that were available.

In this way she built a rapport with him which would allow her future access to advocate the use of modern contraceptives and to educate as to the dangers for women posed by having many children. When discussing her approach with me, she referenced the CHPS training which emphasises the need to be respectful of clients' beliefs, and build relationships in order to affect long term change. This was a particularly powerful message for the CHOs who had received CHPS training, and many of the CHPS officers with whom I spoke in the district were emphatic on the point that they cannot impose their ideas on others, only counsel and allow clients to make their own choices. As one CHO commented:

You don't impose a decision, it must come from the client. We must help clients to make an informed choice.

The CHPS directive to build rapport with clients and counsel based on what they see was extended by many CHOs to the clinical interactions they had with community members. They understood that their role was not limited to providing one particular service at a time, and that any interaction with clients was an opportunity to address any issues they perceived and to educate about reproductive, maternal and child health care. Each CHPS compound runs a child welfare clinic once a month which takes place in the clinic, but for the villages which are not within easy distance of the clinics, the CHOs visit on the same day each month in order to run the child welfare clinic at a central point in the village. During the clinic, women visit with any children they have under 5 years old, who are weighed and assessed by the CHOs, and the children's progress is recorded. For the CHOs, this was also an opportunity to talk with mothers about their reproductive health, and to make themselves visible in the villages which they visited.

Visits to villages to conduct child welfare clinics were well publicised, and CHOs would use their home visits and walks in the community as opportunities to advise women when the clinic was coming up. To ensure maximum participation, the clinics were usually run in each village on the same day each month, on a day which had been agreed with the consensus of the village chief and community leaders. In one case, the CHOs at a clinic explained to me that they had originally set their own day to visit,

but had discovered that the day in question was market day in the village and that no-one would participate in the clinic activities. Their subsequent clinics were run on a day which the village had agreed would be best.

For the village child welfare clinics, CHOs would bring a spring scale for the purpose of weighing children, which they would attach to a tree in the centre of the village previously selected for the purpose and known collectively as the weighing tree. When they arrived, community members who lived nearby would bring a table and stools so that the CHOs and clients could sit whilst they waited. The clinics were well attended, and in some cases as many as eighty children were seen by the CHOs. However, when running the clinics the CHOs generally stayed for most of day, which meant that women could drop by with their children at various points rather than crowding in together which would prevent broader conversations about health care taking place.

The importance to the CHOs of ensuring that they spoke with all mothers was made apparent on one occasion on which a young girl was sent to the clinic, struggling to carry her baby sister on her back. The CHOs sent her back to her house nearby to request that they speak with the child's mother. On each occasion the CHOs would counsel the mother regarding the children's weight and diet, and then ask after mother's health, and, if she had many children or children under 2 years old, they would ask if she had considered using contraception. In cases where women were pregnant, they would check that the mother was receiving antenatal care, and encourage regular clinic visits.

Welfare clinics are social occasions in the villages, and provided an opportunity for community members to discuss health care concerns together with a CHO present. Although men did sometimes come with children, this was a rare occurrence, and for the most part the clinics were a space in which women could discuss pregnancy and contraception in their own villages without fear of incurring disapproval from men in the community. This was a very real concern, as it is a commonly held belief in the district that use of contraception will promote promiscuity and lead to permanent infertility, circumstances which would bring shame to a man and his household. On one child welfare day, a woman arrived with three young children who were seriously underweight for their age. A CHO sat with the woman and explained to her that the children were 'small small', and began to discuss the risks of unplanned pregnancy.

The following comments from the CHO were typical of the approach that the CHOs in the district took when discussing maternal health care with women:

When you have unplanned pregnancy, you ignore the other children and look after the new one. You need time to recover so you can be well, having a child very soon is dangerous. You need more time for your children. You will also have more money for your children if you wait.

The benefits of creating a safe space for women to discuss their health with the CHOs became apparent when this conversation was partially overheard by a woman waiting for her child to be seen, who took the opportunity to ask the CHO about family planning for herself. The CHO explained to her the different options, and invited her to see her at the clinic to receive a three month contraceptive injection to begin with. She explained that she could register to receive the injections in private at the clinic, and ascertained that the woman would be able to afford the treatment which would cost £0.15 every three months. After this conversation the woman agreed that she would come and see the CHO at the clinic soon.

In the meantime, the conversations about the merits of birth-spacing conducted by the CHO had prompted a group of women sitting together to discuss this amongst themselves, and when she was free the CHO joined in their discussion and took the opportunity to answer questions and address any concerns or misconceptions. During the group discussion, the CHO reiterated her earlier comments regarding the danger to women's health posed by having children too close together, and invited the women in the group to come and see her at the clinic to discuss family planning options further.

During their discussion, a man who had visited earlier with his son returned to the clearing where the clinic was taking place, and began to remonstrate with the CHO over her insistence that he would need to take his son to the clinic to be treated for a skin infection. He asked if he could leave the boy in our care, explaining that he had ten living children and was unable to provide for them. The CHO asked him whether he and his wife had considered family planning methods, and he said that he did not want his wife to try this after he had heard that it would make her fat.

The CHO explained that this was not the case, and that he should tell his wife to come and see her at the clinic so she could go through different methods with her.

The man remained adamant that his wife should not use contraception, at which point the women with whom the CHO had been discussing family planning responded angrily to him, telling him not to bother the CHO and that he had to go to the clinic with his wife. The CHO had successfully harnessed the child welfare clinic to support the broader CHPS agenda, facilitating discussions about maternal and reproductive health care and providing a space in which women were able to talk through the options available to them. The group discussion had also emboldened the women present to voice their support for family planning and the CHO.



Fig 21: A busy child welfare clinic, Ghana.

Photo by the author.

When conducting the clinics, the CHOs ensured that they reached as many people as possible when visiting the village. After the clinics were done, the CHOs would often walk around the village, checking that they had seen all the mothers and children, and making themselves visible to people who may have questions for them. On one occasion, a CHO conducting a walk round after a clinic saw a young woman cooking outside beside a group of men. She asked the woman if she has children and she replied that she did not. On hearing this, one of the men said that she must be using family planning, and that she was bad for doing so. The CHO took this opportunity to start a discussion with the group about maternal and reproductive health care:

CHO: Why do you say that, why do you think it is bad?

A: It gives you diseases. Women who use it cannot have children.

B: They bleed all the time.

CHO: Family planning does not make women infertile. There are different types of family planning that work for different times. The injectables last for three months or six months, and the implant lasts for five years. After this she can have children. There are also tablets and condoms – these are also family planning.

A: No, it is bad for you. I don't believe it is ok.

CHO: Lots of medicines have side effects but it does not mean that it isn't good. When I take chloroquine for malaria, I itch for days! My mother itches, but my father and sister sleep for days. Everyone doesn't respond the same.

At this point the men shook their heads, and the CHO decided to try a more personal approach:

CHO: If your sister or girlfriend has unwanted pregnancy would you rather she lost her uterus so she can't have any more children or she died doing abortion, or would you rather she use family planning?

A: Why do you think it is bad to have many children?

CHO: Having children too close together is dangerous for the woman. And for you, if you have many children you need the money to look after them all. It is better to wait.

The conversation ended with the men saying that they would now think about using family planning, and the CHO was pleased that she had had the opportunity to talk to them as a group. During this exchange she demonstrated the benefits of her CHPS training, ensuring that she made the most of the opportunity to discuss family planning and maternal health without confronting or alienating those with whom she was speaking.



Fig 22: A CHO takes the opportunity to talk about family planning with a group of young people in a village.

Photo by the author.

Although the village clinics were officially known as Child Welfare Clinics, the CHOs in the district referred to their village clinics as ‘outreach’, acknowledging that they are there to do more than provide clinical care for children. On some occasions, I noted that the majority of the CHOs’ time in a village CWC was spent talking to women about pre-natal care and family planning, the weighing of children acting as a segue for them to begin conversations about issues of fertility and the health of the mother. On a visit to a remote village known for severe poverty and lack of attendance at the clinic, the CHOs spent the majority of their time talking with women about the importance of pre-natal care and family planning. The women they saw at the clinic had between six and ten children, and several were currently pregnant.

Speaking with a woman who had nine children, a CHO asked if she wanted to have any more children. She replied that she had done something to ensure that she would not have any more. The CHO asked what this was, and learned of a ritual popular in the area whereby women take three drops of placental blood on their tongues to ensure that the birth will be their last. The CHO told her that she had never heard of this, and asked the woman to explain to her how it worked. She was told that it was traditional, and had always been done that way in the woman’s family. The CHO took the opportunity to explain about the different family planning methods that were

available to her, and advised her to come to see her at the clinic to give modern contraception a try.

Although on many occasions the women the CHOs speak with on their 'outreach' feel comfortable discussing reproductive health, it was not so in this village, and the CHO realised that it would not be productive to have such conversations where they could be overheard. She dismissed the women who were waiting, telling them that they needed to fetch various articles such as stools and their babies' weighing slings from their houses. This allowed the woman the opportunity to ask further questions about contraception without being talked about in the village.

Later, the CHO spotted a pregnant woman with a young child and walked over to talk with her. She remembered having asked her to come to the clinic to try family planning, but she had not come. The woman explained that her husband disapproved, thinking that it would encourage her to be promiscuous. The woman then asked the CHO if she had to tell her husband if she used family planning, and the CHO told her emphatically that it was a personal choice, and that she would help her if she decided to do it. The CHO then turned to the question of pre-natal care, and asked if she had been for a pre-natal check-up, concerned because she had not seen her at the clinic. The woman replied that she had gone to the hospital, and the CHO made a note to check her record and conduct a home visit to ensure that she was receiving appropriate care.

The majority of CHOs demonstrated an advanced understanding as to how to speak with community members regarding maternal and reproductive health care. A notable strength shared by many was taking opportunities to discuss and educate in their communities, using their outreach visits to villages to full advantage, seeking women out in particular and ensuring that they made a connection which would encourage women to visit them to discuss contraception and attend pre-natal visits.

They were also often able to read social situations well, taking a different approach to their discussions according what they felt would be appropriate. The CHPS directive encourages the CHOs to counsel based on what they find, and the CHOs interpreted this not only as responding to the practical situations they observed, but also as a need to adjust the tone of their counselling approach based on what they thought would be effective with a particular client. One CHO explained to me the importance of

allowing clients space to tell them their problems, and the need to assess each client individually in order to counsel in an appropriate manner:

We know it should be confidential. And you allow the client to tell you what's on his or her mind, you shouldn't just try to impose. She has to say something. When it's wrong, you correct her in a way that is nice, just keep getting an idea of the person so you come in with your interventions and that will help the client to make the right decision.

Although the CHPS compounds in Shai-Osudoku had only been established for a few years, the benefits of having CHPS staff live and work with each other and the clinic midwives was apparent. The CHPS imperative to integrate social connections with their clinical care in their communities was also reflected in their working lives in the compounds, where sharing clinical activities and judgements was often combined with sharing personal thoughts, helping to care for the children of other staff members, and obtaining advice as to how to advise clients in difficult circumstances. Although the CHOs took the need for client confidentiality seriously, they knew that the midwife was an experienced authority figure who could be trusted, and to whom they were authorised to refer clients where they felt that greater expertise was required.

On one occasion a CHO shared with me the dilemma she was experiencing working with a young woman in the village who had attempted to abort an unwanted pregnancy. She described the multiple issues and interests that become apparent when CHOs live in the communities in which they work, and her uncertainty over how far she was able to intervene in a case of which she became aware through making observations in the villages rather than receiving a client at the clinic. A particular challenge which resulted from this was that she faced trying to mediate observing the woman's right to confidentiality with the imperative to provide medical care for a woman with a high-risk pregnancy. In addition, there were several legal and social conventions at work, including attitudes towards abortion, and the politics of inter-clan relationships. The CHO described her relationship with the woman developing, and her decision to share her concerns with the midwife:

I saw her when I went out to get water. I said 'eh, you are pregnant, come and see me!' She told me she was going to Dodowa hospital but I said she should come to see me at the clinic, I am just here. She then came to see me when I was sleeping. She said she doesn't want it because her mother doesn't like the man. He is from a bad tribe, she knows someone who married into that tribe and

he wasn't good to her. She took a concoction to abort the baby, it didn't work and now she is afraid there will be a defect. She has not come back for any antenatal visits. She has a child by another man and is worried about her reputation. She is keeping it a secret. I cannot talk to her family, but I can talk to the midwife and the midwife might talk to her family if she needs to. If it is a matter of life or death. [The woman] is almost of my age. When the midwife comes, due to her age, she will consider her decision. The midwife is senior, she can assert....there will be a way to approach her so I am sure she will accept it. Because yesterday when I saw her I asked her so is your man still not back, she said yes. I told her I'll be coming to her, so I will go and tell her if she is not prepared to come for the antenatal care I wouldn't be happy if she gets into any health issue or something so I'll just make her aware that I want to talk to the midwife so that she will also see her and try to make things clear to her. The midwife will go to the house when there is an issue that needs her intervention. I'm sure she will counsel her to convince her to start the antenatal care and forget about the abortion so the pregnancy is advanced. I am not a trained midwife, she is trained so she will be able to bring out some of the issues that could affect her health in case she tries to abort.... She wants to abort because she feels like she is moving from one man to another...The parents are not accepting the man. I'm sure if the midwife intervenes and then talks to the parents she will change her mind.

The CHO's account of this case illustrates the way in which the CHPS programme focuses on integrating health workers with their communities allows health workers to address maternal health care holistically. Living in the community provided the CHO with a platform to approach the woman and open up a dialogue which addressed not only the health implications of her pregnancy, but also the social factors which were preventing the woman from seeking appropriate care. Living in the centrally-based clinic, the CHO was available and nearby when the woman decided to talk further with her, and knowing the community she was sympathetic to the concerns of the woman regarding the tribal lineage of her baby's father and her parents' disapproval. Living in the clinic compound in which the midwife was also resident also allowed her the opportunity to seek support from a health worker with more extensive training, and work together with her in order to help the woman.

Limitations of the CHPS blueprint

Ostensibly, many of the CHOs had achieved the much acclaimed CHPS goal of integrating with their communities, and had become figures of trust whom could be approached for health care services and advice. There were many occasions on which

they were approached when walking in one of the villages and asked for help or advice, or just light-heartedly scolded by village women for not having visited their houses recently to say hello. They took many opportunities to educate both men and women about contraception and the importance of pre and postnatal visits and clearly commanded respect in their communities, despite their youth and gender. My initial impressions on accompanying CHOs on their community visits was that they were implementing the CHPS project successfully, and showed a remarkable understanding of their communities and how to talk to people in order to best promote their goals of maternal and child welfare. It also seemed that they generally enjoyed their roles, in particular the fact that they had become trusted community figures. During initial meetings, the CHOs were keen to express satisfaction with their jobs, and all described working with people in the community, especially mothers and their children, as one of the most rewarding aspects of their jobs.

Yet as my fieldwork progressed, it became apparent that the CHOs were struggling to implement the community integration to the level required by their CHPS mandate. During conversations in which we discussed their lives in the community, the CHOs of Shai-Osudoku began to express dissatisfaction with their placements, with common complaints being that being that they found it tedious seeing the same people regularly, and that they were often unable to perform their duties in the way required by the CHPS programme, particularly because many members of the community did not welcome them when they attempted to perform their outreach duties, or were unavailable:

It gets boring. Some people are welcoming but others are not. We arrive and they'll say they are going to the farm.

As my work in Shai-Osudoku developed, the longer-serving CHOs began to comment that although they had not known that the experience of living and working in the community would be this way, and after several years' experience they had now become resigned to the fact that things would not change. The two midwives with whom I worked also expressed a similar resignation, explaining that they had been unable to overcome the difficulties they faced in persuading many community members, from expectant mothers to traditional healers, to work with them.

It is necessary to ask why a programme for which the main focus is integrating health care providers into communities, and which has so many elements designed to secure its success in this endeavour – staff trained in community health counselling, a community base, a long implementation phase, and considerable support from the government and international agencies – has thus far failed to perform a successful integration in the district. I argue that in the process of formalising preventive and promotive aspects of community health care, the health service has created a ‘blueprint’ for building relationships within communities which limits the capacity of health care workers to generate positive maternal and reproductive health care networks within the communities in which they are posted.

The CHPS system is built on the premise that CHOs will live and work in their communities in order to build positive health care relationships. Yet the interactions between health care workers and the communities which they serve are highly scheduled, with CHOs required to visit ten households a day, at least four times a week. The schedule does not allow CHOs flexibility in deciding where more or fewer visits are necessary, and they must follow a checklist of questions during their visits. The effect of this is to create a blueprint for forging relationships for improved maternal health care in communities which only partially recognises the maternal and reproductive health needs of communities, and limits the CHOs’ capacity to respond to individual community requirements.

A common issue experienced by CHOs in all the communities in which I worked in Shai-Osudoku was that community members were reluctant to talk to them, and appeared to resent their visits. Accompanying the CHOs on their visits it became apparent that a significant number of those living in the households on their visiting list were uncomfortable or unwilling to receive them. On one set of home visits a CHO found that several occupants were unwilling to talk to her, and she was not offered a stool as is usually the custom. Her questions regarding the number of children and their ages were not directly answered, and her attempts to explain the benefits of contraception and birth-spacing were met with silence.

At one household, the CHO discovered that one of the women had become pregnant. After she went through her checklist and explained the need to arrange antenatal care, the client informed her that she would not visit her at the clinic

compound because she did not want other community members to see her there. She felt that the community would not approve of her having a second child with a different father, and did not want the CHO drawing attention to her. She said that if necessary she would visit the hospital for pre-natal care, a journey of 10 km which she would have to make on foot. Evaluating these visits, the CHO said:

Some people are difficult and never give the right response to us. If we come and we get a case and we can help them, they are happy, but when they have no condition or have no issues for you to tackle it becomes a pest to them. They can get bored or they are busy or need to work and will not bring a chair. This is how we know. The hospital think that we need to do this every day...this is a small community so we see the same people every day... they [the hospital] say that this is our job and we should go. There is also the problem with regular visits that people start questioning about the person...People gossip, it's human nature.

In order for CHOs to meet their requirement of integrating into the community, they are mandated to make regular visits and are provided with sets of questions and issues which they must go over with the occupants of each household, including educating about contraception and birth spacing. Yet what the CHO describes here are instances where in completing her mandate she is alienating herself from the community rather than becoming a trusted figure. As George et al (2005) point out, where pregnant women's social and economic concerns are not taken into account, general health education reeled off by health care workers have little impact. The CHO went on to express a desire to have more control over the scheduling of home visitations, noting that she would like to be able to tailor the schedule in a way that reflects the needs of the community:

People do not need the visits in the way that we do them. I would arrange it so that before I see a client for the second time, at least one month should pass. Where there is need, for instance if a woman is pregnant, the visits should be every two weeks...the visits should be targeted where there is need...I told this to the hospital but they say it is our job, we must do it.

The desire to be sanctioned to make more individual decisions regarding the need, location and nature of home visitations was echoed by the CHOs at all four areas in which I worked. Here we have evidence that formalising the community networking process has limitations where the model does not allow for agency of those responsible for maintaining it.

As it stands, the blueprint for generating health care relationships does not adequately address the realities of the conditions in which women experience reproductive health and pregnancy. On another occasion, CHOs based in a CHPS zone with no clinic had scheduled home visitations for the morning. We agreed to meet at a central point in the village and walk from there, having first met with a local community health volunteer. One of the CHOs was running late, and her fellow CHO expressed concerns that we might be too late to see the household occupants before they left for work in the fields. At this point, the community health care volunteer pointed out that we were too late in any case, and that households in the area we were due to visit would have been away since five am. When the second CHO arrived, they decided that they would not be able to make home visitations to the community in question, commenting that those particular clients had ‘never been available at the right time’ when they had wanted to visit. They decided that we would visit some of the households nearer by instead, choosing the area on the basis that they ‘had not been there in a while’ and were unable to adhere to the schedule.

CHO home visiting training materials note that visits should be done at times which are suitable for clients, which potentially means that CHOs will have to conduct visits at ‘odd hours’, including outside normal working hours (GHS, 2009). However, this requirement is not supported in practice by the health service, which does not supply the staff or resources necessary to allow CHOs to abide by it, or provide a comprehensive feedback system for the CHOs to report issues such as this. Some of the more remote farming communities which are supposed to be covered by the CHOs had in fact never received a visit from them, meaning that women in this area were not receiving maternal and reproductive health care information or pregnancy monitoring, despite the fact that the CHPS system is officially designed to target such populations.

Here, the visiting schedule – part of the blueprint with which CHOs maintain their health care networks – did not reflect the needs of the community, and led to the CHOs reformulating the network model of community relationships based on what they were able to manage under those conditions. The blueprint, and the informal way in which the CHOs resolved the contradictions they discovered, generates a false impression of successful implementation of CHPS in this area. As Gasper (2000) points out in his work discussing the impact of logical frameworks, use of such

frameworks often precludes the opportunity of learning from issues which arise from project implementation. The formalisation of the community networking process supports the 'myth' of social mobilisation and integration, whilst 'concealing divergent and contradictory logics of practice' (Mosse and Lewis, 2006:16)

During other home visits in the Doryumu area, CHOs visited a young woman with four children, whom they had seen several months previously. At that time they had advised her that she should come to see them in order to receive a contraceptive injection. Due to constraints on the time and resources of CHOs, they had not followed up when she had not come to arrange contraception. When we arrived, we discovered that she was now pregnant with her fifth child. The household in which she lived was large, and the CHOs attempted to deliver their mandated questions regarding the pregnancy and her children in front of an audience, including one of her children whom we discovered had been badly injured in a household accident some months previously. She was unwilling to answer the questions, and before leaving with an incomplete record the CHOs told her that she should come to them to arrange prenatal care. Discouraged and low on both personal and clinical resources, they decided collect supplies from the town rather than complete the requisite number of home visits for the day. Here we see an example of the blueprint for social integration failing to capture the reality of maternal and reproductive health care requirements in the community, resulting in the failure of the maternal health network to reproduce (Lee and Stenner, 1999).

The lack of feedback systems, resources and rewards, together with the problems of isolation felt by health care workers who are installed in new districts to live and work become apparent here. This was exemplified by a CHO at a clinic in a migrant community, for whom the gulf between the blueprint for social mobilisation and the reality of her life there was particularly significant. The district of Shai-Osudoku is home to some communities of Ewe-speaking farming migrants from the Volta region, as is common practice amongst farming communities who move from their home regions in search of land to cultivate (Awumbila et al, 2008). The clinic compound in question lies in an Ewe-speaking community, whereas the CHO speaks Akan, and had not learnt any of the dialect used by the community in which she was posted. Community members rarely visited the clinic, and she could usually only expect to see one patient on days when she was working at the compound. On occasions when she

did see clients, she was obliged to ask a man from the village to come and translate for her. She expressed feeling a sense of futility after two years working at the clinic, noting that the community had no interest in receiving her at their houses and would become evasive when asked questions regarding child welfare and pre-natal care:

We do the visits virtually every day. They are not happy, but it's our work, we have to do it. They are not comfortable so sometimes we do it monthly. If you continue every day, it's a small community they will get tired of you barging into them every day. They are traditional people who would rather seek the counsel of a traditional man than a nurse. There is nothing you can do to change them. They are ignorant and don't know the advantages of the hospital. We have tried to educate them but nothing seems to be changing....if a woman is pregnant we counsel her about pre-natal care she says she will go and then she might not go, and the next time we go for home a visit she might not be there, or she tells you she can't find her [antenatal care] card. That is the problem.

In this case the lack of integration between health workers and this community was so profound that although a midwife had been posted to the area, she had resigned after two years on the basis that local women refused to seek her services. Although building midwife-staffed clinics in rural areas was intended to ameliorate the difficulties posed by living far from the district hospital, in this case the presence of a resident midwife in itself was not enough to make a difference in the community. This is an example of where an increase in available resources and skilled health workers alone is not enough to tackle maternal health problems. The inability of the health service to provide health workers who had the necessary cultural and linguistic skills, and the lack of support available for health workers had led to a failure to generate the relationships of trust between health workers and the community which are crucial to improving uptake of maternal health services.

The CHO's struggle to connect with the village's traditional approach to health care was not unique. The Ghana health service encouraged CHOs and midwives to acquaint themselves with traditional methods and traditional birth attendants in their communities, in the hopes that they would be able to work with them to ensure that women are receiving the care that they require. The CHOs and midwives understood that, where possible, it was desirable to have good relationships with TBAs as such a relationship increased both opportunities to offer them training, and the likelihood that the TBA would refer high risk cases to a midwife. To that end, the hospital at

Dodowa occasionally ran training sessions for TBAs in the area, which taught them to identify signs of complications during pregnancy and delivery and encouraged them to seek help from midwives. However, forging such relationships in practice was a struggle for the CHOs and midwives, particularly because the TBAs were usually unwilling to refer cases and sacrifice the fees they would have received had they performed the delivery. As one midwife explained:

Birth spacing and prenatal care are the most important aspects of maternal health care, and they must come to the clinic for delivery. TBAs should call me if the woman does not want to come to the clinic. This is a problem. They worry that if I come out the client will refuse to pay them. I know the TBA here very well. I tell him he should call me, and that he can deliver. I will check that the woman is fine and give injection. We can work together. But he won't. He thinks he won't be paid. I've told him so many times. He doesn't care about the women, he wants the money. But we must allow [TBAs]. It is worse if the woman delivers on her own.

The blueprint provided for the integration of the social mobilisation mandate with the provision of the CHO's clinical services correctly identifies that placing health workers in communities who formerly had little or no access to health care is a positive step towards improving maternal health care in these regions. However, the ethnographic material explored here provides a brief but alarming picture of the practice of the CHO's social mobilisation mandate. It suggests that lack of policy understanding regarding the material conditions of pregnancy and reproductive health in CHPS communities leads to failure of the blueprint to generate effective maternal health care networks. The system cannot improve whilst there are limited options for health workers to feedback their concerns to the district health administration in a meaningful way, and whilst they are not provided with the motivation and resources necessary to fulfil their mandate. Under these conditions, the attempt to formalise community health care networks fails. As Blomqvist and Levy (2006) point out in their work on knowledge creation and collaborative innovation in networks, it is only when the formal rules of an organisation resemble the realities of actors in its subgroups that the relationship between formal and informal norms and activities will converge.

Health worker coping mechanisms: strategies and brokerage

The health workers residing in Shai-Osudoku faced numerous challenges in their provision of maternal and reproductive health care in their communities. As the material explored here has demonstrated, they often struggled to connect with their communities, and found that the CHPS blueprint for community integration did not adequately reflect their needs or the needs of the population with whom they lived and worked. Many expressed feelings of isolation, which stemmed in part from their remote locations, but principally from the fact that they had little means via which to express their concerns to superiors in the health service and effect necessary changes in their regime. Resigned to the fact that they would have to make the best of their circumstances, the CHOs and midwives developed their own strategies and coping mechanisms which allowed them to continue functioning as health workers and residents in their communities.

During my work in the district I was able to observe some of the strategies, compromises and innovations of health workers performed as a result of functioning under the auspices of the CHPS model for community integration which ostensibly allowed little room for manoeuvre. The reality was that, although the CHPS system had strict requirements regarding the nature and level of community interaction, the CHOs and midwives often failed to comply in practice, and developed their own unofficial policies for community interaction. The result of this was a system in which health workers brokered new strategies for the provision of health care in their communities, and often harnessed unofficial peer networks within the CHPS programme in order to support their responses to the challenges they faced.

One of the most significant adjustments made by the CHOs was a dramatic reduction in the number of required home visits, a factor which severely restricted the crucial branch of the CHPS programme which requires community integration. Although many of the CHOs were highly skilled at counselling and harnessing their roles in the community to promote maternal and reproductive health care, the reality was that they spent the majority of their time in the clinic compounds, treating clients on site and completing copious amounts of insurance paperwork and clinic documentation.

Only a fraction of the prescribed number of home visits took place, and when they did a significant number were unsuccessful due to reluctance on the part of community members to participate, or the fact that the CHOs were not visiting at a time when people were at home and able to talk with them. The construction of clinic compounds in CHPS zones was intended to follow a successful period of community negotiation and integration, after which the compound would act as a spring board for CHOs to perform their duties in their communities. Yet far from successfully connecting CHOs with their communities, the clinics had become static and insular, with many CHOs feeling obliged to stay within the compound walls in order to attend to visiting clients and complete the administrative work generated by the clinic.

Of principal concern amongst CHOs was the fact that in order to complete the home visiting target of ten houses a day at least four times a week, they would need to conduct the visits alone due to lack of staff, and often after dark when the members of the farming community had returned from the fields. During initial training, health workers were informed that the visits should be done at times which are convenient for clients, a requirement which was difficult for them to meet in practice. In addition to lack of staff and scheduling problems, lack of transportation meant that the CHOs would also have to travel long distances on foot to reach some of the communities on their roster. Most of the CHOs in the district did not conduct home visitations alone or at night, an arrangement which they came to after discussions with their fellow CHOs who worked in the community.

CHOs operating at different clinic compounds in the district meet fairly frequently for supplemental training at the district hospital, and to socialise when they can, as in many cases they were in the same nursing school cohort. In addition to the opportunities for discussion presented by meetings at the hospital, the CHOs occasionally took part in 'peer monitoring', an infrequently occurring meeting of district CHOs which allowed them the opportunity to discuss their experiences working in their communities. The risks involved in conducting home visits were a key cause for concern amongst CHOs across the district. One CHO at a larger clinic compound describes an informal meeting of district CHOs in which consensus was reached that it was too dangerous to conduct home visits unaccompanied and at night:

There are risks with it [home visits]. Sometimes when you go to a certain house dogs will be attacking you so we go in twos in case of any problem and sometimes some men... if the person is not normal, he will rape you so we have to go in twos. One of the nurses told us that when she went on home visits and some men in the village said they were trying to rape her. They did not but she became scared. When I came here I was going alone, we were given a [visiting] book each. We were four in number and we divided ourselves, one to each village. But we never did this again. Nobody says we can do this but because of the risk, we had to advise ourselves to go in twos. But it's something they [the hospital] want us to do everyday.

It was in this way that the CHOs in the district brokered new informal policies on home visiting, which they reinforced during subsequent conversations with one another in which they shared their experiences and fears surrounding visiting people in their communities. The CHO explained that although the number of visits required would necessitate the CHOs working alone, they had decided amongst themselves that this practice should not continue. The CHOs put a particular emphasis on articulating the dangers they may encounter if making visits alone, especially the risk of being assaulted after one of the CHOs shared her story of being threatened whilst out alone. These fears were widespread amongst CHOs in the district, and none, whether they were placed in a CHPS zone with a clinic or without, were prepared to conduct home visits alone or at night. The midwives who supervised the CHOs in clinic compounds did not require them to do so, and it was generally understood that in practice it was not feasible to meet the home visiting requirements mandated by the CHPS programme.



Fig 23: CHOs, Ghana.

Photo by the author.

In addition to a general agreement amongst CHOs as to the particular circumstances under which they would not conduct home visits, it was also the case that many more home visits did not take place due to CHOs prioritising other activities. On any given day, they may have scheduled home visits but found that an influx of clients visiting the clinic, or the need to collect supplies from the hospital made scheduling their outreach duties difficult. Under these circumstances, the CHOs would prioritise the maintenance of the clinic, and would frequently say that they would go another day for the visits when it is quieter. In one of the well-established clinics, the CHOs had developed a monthly timetable of activities which set aside an entire week for all staff to complete insurance and administrative paperwork which included reports on the clients seen in the clinic:

	Mon	Tues	Weds	Thurs	Fri
Week 1	Clinic CWC	CWC Outreach	CWC Outreach	Home Visits	Home Visits
Week 2	HV	HV	HV	HV	CWC Outreach
Week 3	HV	HV	HV	HV	CWC Outreach
Week 4	Report Writing	Report Writing	Report Writing	Report Writing	Report Writing

Fig 24: CHO schedule

In reality, the CHOs were rarely able to stick to their timetable, and it was only during week four that they adhered to their agreement, determined to complete the necessary paperwork in order to avoid censure by the clinic midwife or the authorities at the district hospital. There were also times when the CHOs would conduct home visits, but decide to abort their trip without completing the requisite ten visits for the day. The decision to curtail visits was usually influenced by a number of factors; the CHOs were often concerned that they should leave time in the day to get supplies for the clinic, or personal supplies for themselves, but such decisions often coincided with visits which were particularly fatiguing due to the distance walked in the heat, and also the reluctance on the part of community members to cooperate. The decisions taken by CHOs to deviate from their timetable represent another kind of brokerage which

occurs on a daily basis as they attempt to accommodate the demands of running the compound and the increasing number of visitors to the clinic.

A further example of brokerage emerged from discussions surrounding the low numbers of deliveries which take place at the CHPs clinic compounds. At one clinic, CHOs reported an average of one or two deliveries in the clinic a month, with many months having passed without any having taken place there at all. One CHO explained that when pregnant women are seen by the midwife at the clinic, she claims that the birth will be complicated and refers the woman to the district hospital at Dodowa, about 20km away. During interviews, the midwife said that “any little complication I will send them to Dodowa – they have the proper facilities”. This has become a pattern which alarms the CHOs at this clinic, who note that all women are assessed as having potential complications, although these are often not appreciated by the CHOs. It is understood by those in the community that the midwife at this clinic will not perform deliveries at all, and, according to the CHOs, community members have taken to referring to the midwife as ‘Dodowa’, after the hospital to which she sends women to deliver.

The implications of this for the provision of maternal health services in the area are severe, the hospital being too far away for many women to walk to or pay for transport. Although this issue is causing serious concern amongst CHOs, none have communicated their concerns to the midwife or their supervisors in the district health authority, and instead collaborate in perpetuating the idea that the pregnant women they see are high risk and needed to be referred when asked by district inspectors why the clinic birth rate is low. They have discussed ways to inform the district health authorities, but none have acted on it. One CHO explained their approach to this issue in their clinic compound:

It is fear. When you hear the stories in town about the midwife, they are saying when they come here the midwife will tell them to go to Dodowa. Meanwhile there is no problem with the person...The midwife is supposed to deliver the person here, unless there are complications...but where there is no problem she still tells the person to go to Dodowa. People do not come to this clinic to deliver. They are afraid to come – what they are saying in town is that she will tell you to go away, so they wouldn't even come here now. They are really complaining...They have named her 'Dodowa' because when you come she says go there....Some will go to Dodowa but others will deliver in the house. We can't tell about this, we will be in trouble. There is a suggestion box at

Dodowa, I was suggesting we could write and put it in the box, but I don't know. Maybe I'll write it and ask a client to put it in. That way they will not see it is me. I can't talk.

The number of deliveries which took place at district clinics which were staffed by midwives was low, usually coming in at about five a month. Many women preferred to give birth at home, even if they had previously been receiving antenatal care at the clinic, a fact which the CHOs found frustrating. In this particular clinic, the midwife was reluctant to perform deliveries there at all and felt that the hospital was a much better alternative. However, rather than explain her concerns to the district health administrator, she said consistently that the women she saw were at risk of complications and therefore should be referred to the hospital as per the district guidelines. Her preference that women deliver at the hospital rather than the clinic was widely discussed in the community, and people had come to feel that there was no alternative between delivering at home, and traveling to the hospital at great expense, where they would deliver amongst strangers.

In one case referred to in chapter 4, a woman who had been visiting a clinic for antenatal care went on to give birth with a TBA at home. She came into the clinic the next day with severe abdominal pain and bleeding, which alarmed the CHOs. As the midwife was away, they instructed the woman to go to the hospital at Dodowa as soon as possible. She told the CHOs that it was difficult for her to get to the hospital, and that she would have to wait for her husband to return the next day with money for transport.

Theoretical reflections: formalising networks

The ethnographic examples discussed here draw together a picture of a formalised system of community health care networks which only partially recognises the maternal and reproductive health care requirements of the communities in which it operates, and the needs of the health workers whose role it is to implement the system. In what follows I explore the themes which have emerged from this research, including what I have come to view as the blueprint for implementing community health care, the construction of community health workers, and the brokerages, unintended effects and relationships which emerge as a product of a health system

approach which simultaneously disallows health worker innovation in maternal and reproductive health care strategies, and produces it.

Integrating social and clinical components

The CHPS approach to integrated community health care acknowledges the need for health workers to form positive relationships community members in order to increase the uptake of clinical services, especially with regards to maternal and reproductive health care and child welfare. Yet the ethnographic evidence explored here suggests that health workers' ability to forge positive maternal health care networks in their communities is often limited by the very mechanisms that are supposed to facilitate this. The health service prepares CHOs to take on their new roles through partnerships with donor organisations, particularly USAID contracting agencies, who provide technical assistance in developing human resources through training activities including 'social mobilisation skills' (Ghana Health Service, 2002). The view of the health service is that it is through such training, policy guidelines and management procedures that the community health system can be successfully 'integrated into existing structures and functions of the Ghana Health service' (GHS, 2002). On the basis of this, CHOs are required to follow specific schedules and guidelines as to the interactions they have with community members, and the topics they cover when making home visitations.

The requirements to collect information from households regarding pregnancy, and advise on reproductive health care are vital, and are hugely significant in providing households in geographically remote areas with health care services and information that they would previously not have been able to access (Awoonor-Williams et al, 2013). However, the staffing and scheduling of CHO activities mean that some households miss out on CHO visitations when members are not available, and others receive regular, non-specific visits which are sometimes resented. The lack of sustained training and discussion surrounding counselling skills and the prescribed nature of points raised during visitations sometimes lead to health care issues going unaddressed, and the alienation of community members.

A further factor which prevents health workers from forming sustained health care networks in some of the communities they serve is that the CHPS blueprint does not

make adequate provisions for different kinds of community living and social arrangements. Many of the households in CHPS belong to farming families, and as such household members are often away from early morning until night. This means that CHO's rarely if ever make visits to these households, a fact which has severe implications for maternal and reproductive health given that that majority of food crop farmers are women, and amongst the poorest in the area.

Visitations are organised by household, which means that informal residences and social groups are invisible to the system, and the potential of health workers to connect with them is lost through the process of formalising and prescribing their networking activities. The WHO (1999) highlights that one of the increased health risks presented by informal residences is the difficulty of collecting census and other information which is vital for the appropriate provision of health services. This is particularly problematic in migrant communities, and poorer communities where the constitution of large households is difficult to keep track of. The effect of the blueprint for social mobilisation is often to limit rather than enable health care workers to formulate and maintain effective health care networks in their communities, where only certain kinds of maternal and reproductive health care requirements are made visible within the system.

Constructing community health workers

One of the most instructive elements to emerge from the data explored here is the way in which community health workers themselves are constructed through attempts to integrate social and clinical services. Observing the activities of health workers on a daily basis and to listening to them discuss their own lives and perceptions of their roles made it clear that many embodied the awkward relationship between social and clinical services which they experienced on a daily basis, and which often had a profound effect on their sense of self and wellbeing. The process of constructing health workers as embodying both strands of the integrated health system began in the conceptualisation of their roles at the policy level, and was enacted through their daily activities as they attempted to fulfil these roles.

The emphasis on the CHO's role in mobilising community participation and connecting with individual community members is seen at a national and international

level to be one of the CHPS programme's greatest strengths. In order to prepare CHOs for their new dual roles providing both clinical and social care in their communities, the programme requires that CHOs develop the skills required to fulfil the social necessities of health care provision in their communities. Therefore, in addition to acquiring enhanced clinical skills, CHOs are trained in building relationships with community members and given counselling skills. Much emphasis in health service literature is put on empowering CHOs through training and skills workshops to generate social mobilisation and improved partnerships with the communities in which they are posted (GHS, 2002; Binka et al 2009; Awoonor-Williams et al, 2013).

Integrating community mobilisation with health service provision is seen to rest on the transformation of Community Health Nurses who work with CHPS into CHOs, who are given new skills with which to perform this integration on a day to day basis. The title "Community Health Officer" was selected deliberately to avoid their roles being construed by their communities as purely clinical, and to represent the fact that they are trained to manage community health care relationships (Ntsua et al, 2012). Health service literature describes the need to build the capacity of CHOs to provide both curative and promotive services, by designing training programmes which enhance their technical skills and designing a schedule of community entry and visitation which allows them to build trust in their communities.

Eade (1997) argues that effective empowerment of actors in development contexts means enhancing existing and potential relationships, rather than just increasing the number of 'partners' or opportunities for contact. The ethnographic data explored here suggests that the emphasis is indeed on maximising CHO interaction with community members, without necessarily providing CHOs with the means to enhance such relationships. Here the principle of community health care networks is endorsed, but health workers have little capacity to develop the substance and character of health care networks which is necessary in order to maximise the benefits of an integrated health system. Health policy literature defines the concept CHO empowerment narrowly – almost exclusively in terms of the training that is or should be made available – whilst neglecting the broader elements of CHOs' lives in their communities which influence their efficacy in terms of successfully integrating services.

Kaplan (1999) highlights the tendency of organisations involved in development practice to provide training in new techniques in order to satisfy mandates for practitioners to offer a new or improved service, often at the expense of providing practitioners with the opportunities to respond sensitively and appropriately to a given situation:

...you have to develop effective development practitioners, practitioners who do not work out of books or project manuals, practitioners who do not 'work primarily out of the specifications of the world from which they have been sent' but rather 'out of an accurate and sensitive reading of the particular situation with which they are faced'. And this does not mean training them in new techniques, but fostering their development through guided reflection on action, facilitated self-critique, mentoring, peer reviews, and so on (Kaplan, 1999:18)

In constructing the concept of the CHO from a purely instrumental perspective, the health service leaves little opportunity to discuss how CHOs might be empowered in ways that would enable them to make decisions based on their own findings and experience. Viewing the integration of curative, preventive and promotive services as instrumental also has particular implications for the provision of maternal health care, as building and maintaining strong community relationships which allow health workers to monitor pregnancies and educate around reproductive and maternal health care is crucial.

According to Eade and Williams (1995), effective strategies for empowering development practitioners means allowing workers to determine priorities and providing them with the appropriate means with which to effect change. While CHOs have officially been sanctioned to integrate the crucial preventive and promotive aspects of maternal health care into their activities, their capabilities are severely limited by the instrumental conceptualisation of these elements of the integrated service. Translated into the existing policy language and structure of the health service, the concept of community engagement has emerged having been stripped of the elements which would serve to empower health care workers to effect the social mobilisation pillars of their mandate.

In addition to a narrowly constructed role, CHOs in Ghana are further undermined on a number of levels, having few avenues to effect change either in their

communities or in the health services of which they are a part, few prospects for career advancement, extremely low wages and difficult working conditions (Pillinger, 2011). A significant problem identified by health workers in Shai-Osudoku was that they have little power to influence the official policy which determines their roles and duties. Indeed, a report on the CHPS programme (Binka et al, 2009) note that the programme suffers from a lack of understanding of the CHPS concept, particularly with regard to the planning component, which has led to weak partnerships amongst stakeholders. As key stakeholders, the report advocates greater CHO involvement in the planning element:

Since CHPS zones are an integral part of the sub-district, so all CHO should be involved in the sub-district planning. This would help them to build their own capacity to develop their own plans. (2009: 27)

The data explored here also reveal a degree of the personal risk CHOs assume when they take on the role, with some having had to make home visits alone after dark, and some having experienced threats of rape as they are conducting their duties in their communities. In a review of international occupational health regulations, Lethbridge (2008) notes that common occupational problems suffered by women health workers in particular are violence and sexual harassment, leading to low morale and feelings of shame. The negative experiences of women health workers are often compounded by the low pay and insecure employment they often face in the health care industry.

Examining the health and safety issues affecting health care workers in Ghana, Clarke and Sutherland (2007) observed that occupational health and safety was poorly understood by both health workers and management. Examining both the perceptions of health workers and interventions, they found that while psychological issues were one of the main causes for concern amongst health workers, reporting was extremely low and there were no clear avenues to report or investigate problems. These issues were reflected amongst health workers in Shai-Osudoku, who felt unable to report the problems they experienced conducting home visits in their communities, and resolved amongst themselves to put informal policies in place to protect themselves.

Many CHOs also expressed feelings of isolation, and in several cases expressed the view that they were not able to fully integrate themselves into their communities. In

addition to the various problems associated with home visits already discussed, some health workers had been placed far away from their families, sometimes in communities in which the people, language and culture were alien to them. The GHS (2002) recognises that national posting and recruitment procedures can result in CHOs being posted to areas where languages, social customs and organisational structures are unfamiliar. One of the long term aims of the CHPS programme is to attempt to organise recruitment on a regional basis, a plan which will involve significant restructuring. Currently, one observes situations such as that which I have discussed in which health workers reject, and are rejected by, the communities in which they are posted, are unable to speak the local language, and are thoroughly demoralised. In the case discussed here, this led to the resignation of the midwife assigned to the community, on the basis that community members would not use her services.

CHOs are provided basic training to build skills for interacting with their communities and counselling on use of contraception and pregnancy. It is in this way that they make the policy journey from Community Health Nurse to CHO, but it is a process which occludes mechanisms which would formally empower them, either by recognising their own needs with regards to living and working in their communities or by providing a comprehensive feedback system for them to communicate this. This limited development of the concept of the CHO has led to a practical situation in which CHOs are often compelled to create new informal rules and policies in order to cope, sometimes in collaboration with other health workers.

Health worker coping mechanisms, strategies and brokerage have become a key feature of their daily lives, sometimes emerging from attempts to improve the care they provide to their communities, and other times from necessity, either for their own well-being, or because they were unable to meet the demands of the CHPS programme. Health workers had become the architects of the version of the CHPS programme that was implemented on a day to day basis – they were, as Goetz (1996:122) has put it, ‘de-facto policy makers’.

The ethnographic material explored here presents a picture of an emerging health care context in which many of the strategies and coping mechanisms employed by health workers skewed programme implementation away from the social component, a

circumstance which critically undermined the potential of the integrated service to improve reproductive maternal health. One of the central advantages of placing CHOs in communities to do outreach work was that they could track the progress of pregnant women and follow up if they failed to attend pre-natal visits. Their community position also allowed them to help women with contraceptive medication, following up when necessary, and advocating clinic services to women. A reduction in community outreach services meant that the CHOs reached fewer women, and their attempts to build relationships of trust which would help in advocating clinic services were undermined.

Health workers deciding to conduct home visits in pairs and in the daytime only is an example of brokerage which meets the needs of health workers to operate within a safe environment, but which negatively impacts on their ability to successfully maintain networks for maternal health care by making the requisite number of home visits. In some cases, health workers were unable to conduct visits due to the fact that some community members were not available during the daytime, while in other cases they were deterred from making visits due to the poor reception they received from some community members, and a general lack of cooperation. In the CHPS zone where no clinic had yet been built, health workers struggled from lack of resources and support which further contributed to their difficulty in performing home visits, and were not living in a strategic place in their community to make them easily accessible by members of the community.

CHO strategies often prioritised the demands of their clinical duties, record keeping and paperwork over community outreach. The burden of paperwork on CHOs cannot be overstated; in the clinics in which I conducted my observations, CHOs reserved one full week out of four in their timetables for clinic record keeping, report writing and insurance paperwork, the latter of which was substantial and had to be submitted each month. A further consequence of their reduction in community work was that community health care volunteers were often more available to community members than CHOs, which placed increased demands on CHVs who were unpaid, employed in other roles, and had little training. In addition to untenable demands on their services, CHVs were less able to connect with CHOs to refer cases and receive support as a consequence of the CHOs' diminishing involvement in community outreach. The reduction in community outreach performed by the CHOs in Shai-

Osudoku is supported by reviews of CHPS implementation which note that CHOs are spending more time in their clinics, and failing to make connections in their communities and with community health volunteers:

A new structure has emerged: CHOs are running static clinics, without outreach services as originally envisioned by CHPS. CHOs complete fewer and fewer home visits and more and more facility-based, curative care. This new structure has altered CHO operations, and by default, CHOs' FP role and delivery of other convenient, home care is inevitably shifting to CHVs, although CHVs are ill equipped to provide them.... This situation not only over burdens the dual cadre model but also dilutes, or even defeats, its purpose (Ntsua et al, 2012:14).

Observing the strategies of health workers is essential for what these tell us about the system in which they were generated. The approaches of individual health workers explored here can be interpreted as responses to gaps in the health systems in which they operate, and when viewed cross-district reveal repeating patterns in health worker strategies which reflect the most pervasive problems in the community health system. Wolf (1956:66) quoted in Mosse and Lewis (2006:12) provides a summary of this point which is particularly useful, commenting that the study of such actors can “provide unusual insight into the functions of a complex system through a study of its dysfunctions”. In the case of the CHPS system, these dysfunctions point to both the conceptual and practical limitations for the advancement of maternal health care posed by the integration of services.

Chapter 8: Integrating Social Initiatives:

Emerging lessons from two health systems

The purpose of this concluding chapter is to review my key findings, and to put evidence from the countries in which I conducted my research into perspective vis-à-vis one another. Viewed in this way, the artefacts which emerged from the health systems of both countries point to fundamental deficits in the provision of maternal health care, in addition to highlighting the critical role of health worker strategies. A principal point of investigation has been formal and informal attempts to integrate non-clinical interventions including educative, preventive and advocacy-based initiatives with the provision of clinical services in communities. I conclude by offering some insights into how such integration has been effected in each country, and what this suggests about how integrated systems might be improved to benefit maternal health care provision.

Here I will argue that the strategies employed by community health workers are central to both the maintenance and improvement of maternal health care services in both countries. These actors negotiate the provision of care within their communities on a daily basis, responding to contextual factors and sustaining health systems which give them limited room to manoeuvre. The deficits of the health systems in which they operate have devastating consequences for women, who often do not receive the information or care required in order to secure safe pregnancy and delivery. In taking the patterns generated by health worker strategies as an entry point for analysis, I am offering a methodological contribution to the study of maternal and reproductive health care which allows researchers to better view the problems inherent in current maternal health systems.

Key findings

Although both Mali and Ghana have a considerable way to go before they reach the millennium development targets for maternal health, Ghana now has far better maternal outcomes than Mali. This cannot be understood purely in terms of access to health care and resources. Whilst these are highly significant factors, evidence from both countries suggests that maternal outcomes are more complex, and require an

analysis which takes into account the relationships and strategies brokered through the everyday practice of community health care. For those who practice it, maternal health care is primarily about relationships. Connections between health workers and their communities, between women and their partners and families, and between health workers and their fellow medical personnel are all central to advocating and delivering maternal health care services.

In both Mali and Ghana, community health workers made efforts to form the relationships with one another and their communities that they required in order to further the provision and promotion of maternal health care services. The success or limitations of their efforts had a profound impact on the uptake of these services. In the Kati district of Mali, many community health workers attempted to create and maintain networks between themselves and their communities, approaching women to offer advice, and liaising informally with community leaders in order to advocate the maternal and reproductive health services offered by their clinics. Similarly in the Shai-Osudoku district of Ghana, health workers lived and worked in their communities, forming relationships with community members and taking opportunities to talk to individuals and groups about clinic services which would improve maternal health outcomes. In both regions, it was understood by health workers that uptake of family planning and clinic pregnancy services required not just access to health services and resources, but an investment in relationships between themselves and their communities. Becoming a well-known and trusted figure in their communities was a key basis from which health workers could encourage uptake of clinic services and monitor pregnancies.

Formal and informal networks

Although building community networks to improve understanding and uptake of maternal and reproductive health care services was central to both Mali and Ghana, the place of these networks in their respective health systems was very different. The networking activities of health workers in Mali took place largely outside of their official mandate, and included offering advice to women as to how to convince their husbands as to the benefits of clinic services, and receiving patients at their own homes. These were informal activities which were based on the initiatives of health workers operating alone, or with other staff members of the clinics in which they

worked. In contrast, the health care networks maintained by health workers in Ghana were part of the CHPS programme designed to integrate health workers into their communities, and put them in a better position to advocate clinic services. Here, the networking activities of health workers constituted a formal part of the health system, and health workers were required to maintain these in addition to performing their clinical duties.

In both cases health workers experienced problems in forming and maintaining adequate community relationships, issues which often reflected the limitations of the health systems in which they worked. In Mali, health workers had limited time and resources to build community relationships, and had no formal mandate to see community members outside the clinic on a regular basis. In areas where the population was growing rapidly, health workers reported feeling unable to provide more than clinical services on the grounds that they had too many people to treat, and did not know community members well enough to discuss family planning and pregnancy unless they came to them as a patient. Health workers in Ghana reported that many of the home visits they performed as part of their CHPS mandate were unnecessary, and in some cases, unwelcome. In other cases, they were not able to perform the requisite home visits, either because they did not have enough staff members to complete their visits safely, or because some of the community members on their rota were away at work in the fields from early morning until late.

Health workers' networking activities were not only central to the advocacy of maternal and reproductive health services in both countries, but also central to understanding the gaps in each health system's maternal and reproductive health care provision. The way in which health workers responded to the limitations of the health systems in which they worked was highly instructive. In both Mali and Ghana, the activities of health workers which took place inside and outside of their health system mandates were negotiated as they navigated both the opportunities and limitations inherent in the systems in which they worked. Those who could not meet their formal requirements, or found there to be fundamental deficits in their formal mandates, would regularly initiate their own strategies in order to facilitate the provision of maternal and reproductive health care in their communities. Their daily activities were often determined by the necessities of the context at hand, rather than by a strict adherence to the formal health systems of which they were a part.

Strategies and brokerage

A central point to emerge from this research is the importance of understanding health worker discretion in improving health systems. Those who work at the interface of health service delivery are not only the public face of health systems, but also play a critical role in determining health outcomes in the communities in which they work. The health workers at the heart of this research are the often first port of call for women in their communities and have considerable discretionary powers. As such, their strategies play a key role in shaping the opportunities available to women in their communities, and understanding the way in which health worker discretion operates becomes a central part of the project of improving health systems. In the first part of the thesis I referred to literature exploring the importance of front line worker discretion, in particular the work of Michael Lipsky (1980) who highlights the role of front line workers in structuring the lives and opportunities of those to whom they provide services. Lipsky emphasises the relative autonomy from organisational authority which generates space for field level discretion, a fact which my research has demonstrated is compounded when applied to the experience of health workers living in relative isolation from the health services for which they work.

My research suggests that the discretion employed by health workers is not only considerable, but that health workers are in a unique position to respond appropriately to the needs of the communities in which they work. In examining the positive contribution that health workers can make I referred to Tendler (1997) who emphasised that the dedication and understanding of health workers are crucial to improving health outcomes in the communities they serve. Many of the health workers with whom this research was conducted in Mali and Ghana demonstrated a high level of engagement and understanding of the experiences of the women in their communities, and made considerable efforts to open up health opportunities for them. Whilst the health systems in which they worked did not engage with the vision of community health workers as agents of social change as suggested by the Alma Ata declaration on primary health care, many health workers in both research contexts took it upon themselves to negotiate improved health and rights for women in their communities. They did so in a number of ways, principally by advocating women's access to maternal health care and contraception with husbands, families and at community events.

The case studies explored here demonstrated the potential of health worker discretion to improve health systems, but also underscored the obstacles they faced in their attempts to do so. In the contexts discussed here, examining the discretion employed by health workers in response to problems they encountered was central to revealing factors such as health system structure and community beliefs and values which shaped the health and lives of women. Health worker discretion was revealed to be not only a means to improve services offered, but a key factor in helping to identify structural deficits which undermine the health of women in the communities studied.

The strategies employed by health workers for coping with the gaps in the health systems of which they are a part were a significant finding from my research in both Mali and Ghana. In many cases, the initiatives of rural health workers did much to promote clinic services, and to provide culturally sensitive care which addressed the needs of individuals. CHW strategies also allowed them to eke out a place for themselves both as part of their health systems and also as part of the communities in which they lived and worked. The ethnographic data collected from both countries also points to cases in which these strategies were unsuccessful, or detrimental to the provision of health services. These examples are particularly instructive for what they tell us about the gaps in each health system, and serve to highlight the particular way in which maternal and reproductive health care suffers as a result of these deficits. Viewed side by side, what these stories reveal is that CHWs are central to the administration of health services in ways that go far beyond that which is expected and understood by the health policies which dictate their roles.

One of the principal strategies employed by health workers attempting to advocate use of contraception and antenatal care services is that they used their knowledge of their communities to develop effective ways of talking to community members about reproductive health. As I have discussed, health workers in Mali did much to form networks with their communities, and used their extensive knowledge of local cultural and political contexts in order to create productive health care relationships between themselves and their communities. Matrones in Mali devised methods of discussing the benefits of reproductive and maternal health services with husbands and fathers who had a range of concerns about the clinic, whilst clinic heads would use their understanding of local politics to create positive relationships with community leaders who could help advocate services. Consent from husbands and family members for

family planning, and use of clinic services for antenatal care and delivery was a significant barrier to uptake of services in the Kati district, a fact which many health workers responded to by talking to dissenting parties informally in an effort to educate and reassure.

Several health workers in the Kati district also advised women as to the most effective way to talk to concerned partners about the benefits of the clinic and of family planning. Despite the fact that much of these activities occurred outside their official mandate, this process of 'translation' performed by health workers proved to be highly effective in cases where they had access to affected women, their families and community leaders. The issue outlined by many health workers was that they had limited opportunities to help people in this way, because they spent the majority of their time at their clinics and could not reach many of the people in the district who would benefit from their advice. The village relais who were mandated to perform this role often struggled to do so, as their positions were voluntary and traveling between the clinics and their villages was difficult.

In contrast, community health workers in Ghana were expected to be available to advise women in their villages, and were instructed to visit the homes of community members regularly in order to engage in advocacy work. As they became more familiar with the villages in which they worked, they developed their own strategies for talking to people, and explained that rather than pushing their own medical agenda, it was often more effective to invite community members to discuss their own views on family planning and pregnancy. Approaching people in this way allowed them to better understand people's beliefs and concerns, and to build a relationship with them which they could use to advocate the services provided by the clinic. In many cases I observed, health worker approaches to their advocacy work showed a deep understanding of their communities, and were effective in promoting good maternal health.

Yet a common complaint amongst health workers in Shai-Osudoku was that their mandate to complete a large number of regular home visits actually alienated community members, was impossible to maintain in practical terms, and prevented them forming relationships through which they could better advocate clinic services. The picture that emerged from Ghana was a community health worker cohort which

felt that they were mandated to form relationships in their communities, but that the structure in place to accommodate this allowed them little room to do this in the ways that they felt would be most beneficial. Ethnographic evidence from Shai-Osudoku points to cases in which due to structural constraints, health workers would see some people too often, and could not reach others.

Some of the strategies employed by health workers in response to the constraints placed on them hindered the advocacy of maternal health care. Health workers in Shai-Osudoku realised that they could often not complete the requisite amount of home visits unless they were prepared to make their visits alone and in the evening. Unable to communicate these difficulties at a district level, they agreed amongst themselves that this was dangerous, and therefore reduced the number of visits they made by traveling in pairs, and keeping to more accessible areas.

Here they had developed a strategy which was necessary to protect them, and which revealed a key deficit in the health system. In the case of the farming communities who were not available during the day, health workers resolved that it was not practical for them to visit these areas, and they would keep to villages where they were able to reach people at times they could manage. Here again the “blueprint” imposed on CHWs for making home visits was not feasible in practice, requiring them to strategise together in order to come up with a rota that they could manage.

In Mali, my research showed that in some cases health workers were unable to implement their own strategies of discussing maternal health and performing advocacy work. In the case of the larger clinic in a densely populated area, their community networking strategy failed because saw large numbers of people, and were becoming less familiar with the communities they served. Health workers from clinics in smaller communities were able to build stronger relationships, but only with people in the vicinity of the clinic and their homes. These cases demonstrate that there are limits to the efficacy of health workers’ networks, where their networking activities are not supported by health care policy or infrastructure.

A further element which was revealed by examining health workers’ networking activities was the degree to which these not only informed relationships between health workers and their communities but those between health workers themselves. Health worker socialities emerged as a principal component of community health care

through which the opportunities available to women were enhanced or diminished. In Mali, cases in which clinic nurses and matrons worked together to advocate women's access to maternal health care and contraception demonstrated the way in which health workers can collaborate to enhance women's access to health care. Here, health workers bolstered the health networks they had created in their communities by recruiting their colleagues for the shared goal of improving the health of women in their communities. The case studies explored here demonstrate that health workers employed different strategies with which to recruit community members into the health networks they had created according to their roles and the opportunities available to them. By working together, health workers occupying different roles were able to extend their networks, for example through using the clinical expertise of nurses in conjunction with the community knowledge and trust with which matrones were endowed.

Health worker socialities were also a crucial factor in determining the way in which the CHPs programme operated in Ghana. In this context, health workers' community networking activities were impeded by several factors, including limited time and resources, and a lack of means via which to communicate the difficulties they experienced to the district health administration. Where health workers were unable to extend their community health networks to the communities in which they were most needed, they responded by collaborating amongst themselves to generate approaches to their roles which would enable them to function safely. Here, health worker networks emerged as an artefact of the obstacles they experienced, and became the conduit through which alternative versions of the CHPs programme were formulated and implemented.

Impact of health worker strategies on maternal and reproductive health care provision

Ethnographic evidence from both Mali and Ghana shows that health worker strategies are a product of deficits in the respective health systems in which they worked. It also indicates that these strategies have a unique impact on maternal and reproductive health. In order to reduce maternal deaths, birth-spacing, planned pregnancies, antenatal care and delivery plans are essential. Achieving this in the communities in which I worked requires health workers to build relationships of trust

with community members, and to have the time and resources to perform the advocacy work necessary to educate women, their families and community leaders about the benefits of planned pregnancy and clinic care during pregnancy and delivery. The initiative shown by Malian health workers in approaching women, their families and community leaders and allowing women to visit them at home for advice without doubt resulted in a greater uptake of clinic services. Further, their strategies demonstrate the potential of health workers to enhance the opportunities available to women. Their initiatives also revealed deficits in the health system which significantly impact maternal and reproductive health care. Although in many cases the networking initiatives of health workers brought success, without a health care infrastructure which supported these activities, they were only able to perform them in a limited, localised way.

In Ghana where the health system is designed to facilitate community-health worker networks through which this advocacy work might be performed, the way in which the service was designed meant that it could not be properly implemented. Health workers struggled to build the relationships with women and their families required in order to facilitate their advocacy work, and could not reach many community members including pregnant women who were least likely to come to a clinic for antenatal care. Here, although the need to build community relationships and perform advocacy work was formally recognised, the health workers did not have the resources to adequately perform this aspect of their roles. The strategies they developed in this case included reducing the number of home visits, and focussing increasingly on their duties in the clinic for which they were more prepared, and which yielded more tangible results.

The strategies employed by health workers in both Mali and Ghana in large part reflected the failure of their respective health systems to adequately integrate non-clinical interventions which rely on health workers being able to perform advocacy work in their communities, with the provision of clinical services. In Mali, this integration was largely informal and health workers were compelled to perform the majority of their community and advocacy work on their own time, their clinical duties forming the basis of official health service provision. Whilst health workers in Ghana had a formal mandate to perform home visits and network with community members, the health service blueprint for this part of their role did not adequately

take into account the needs and experiences of women or health workers, meaning the social side of the programme was poorly implemented.

When reviewing these key findings it is also necessary to acknowledge the limitations of the data collected, and the areas which would benefit from further investigation. Whilst the qualitative methods selected for the purposes of this investigation revealed much about the lives and experiences of health workers in both contexts, there were limits to the data that I was able to collect. One of the principal impediments to collecting the necessary data was the fact that my time in the field in Mali was cut short by the political instability which ensued during my fieldwork in the country. This prevented me from following up on several of the key interviews which I had conducted, particularly with regard to the obstacles encountered by health workers both in the execution of their duties, and in their informal health related activities in their communities. I was able to collect a considerable amount of data regarding the problems encountered by health workers with regards to the attitudes of women's husbands and families towards contraception and clinical care, but collected less data exploring the limitations of the health services in which they worked.

The interviews and observations I made regarding this issue suggest that there is much more to be learnt in terms of health workers' relationship with the health service, and the new challenges that are presented by growing populations and changing community demographics. Exploring these elements would contribute much to understanding the factors which impede health workers attempting to improve the maternal and reproductive health and rights of women in their communities. The deficit in the data collected on the subject of pressure on health services was due in part to the fact that the research was cut short, but also to the small scale of the study. Only one of the four clinics studied in Mali was affected by a significant population increase which, whilst it highlighted the issue, left little room to fully explore the way in which this factor influenced the activities of health workers.

The research in Ghana was also shaped by the fact that limited time was available in which to conduct the study, due to the fact that time available for research had been diminished by the delays inherent in setting up a new research location. Whilst this problem was not as profound as in Mali, there were elements of health workers' experiences that it would have been beneficial to explore more thoroughly. In

particular, much of my time in Shai-Osudoku was spent observing and interviewing community health officers, work which would have been enhanced by more detailed observations and interviews with the other community health staff who were involved in the running of the clinic, and the community health volunteers attached to the clinics in which I worked. The challenge of conducting a detailed study into the activities and understandings of community health volunteers is that, as volunteers, they have other occupations and are difficult to connect with on a regular basis. However, the benefit of such a broader study would be to help establish the connections between different community health roles, and the impact these have on maternal and reproductive health services.

In both contexts, investigations into community health care and maternal outcomes would benefit from expanding the participants to include district health staff and administrators. Whilst beyond the scope of this study, including these actors would help to further situate the activities of community health workers in the context of the district health services to which they report, and shed light on the degree to which community health officers are influenced by health service management and policy.

Integrating social and clinical components of medical provision for improving maternal health

My thesis contributes to the study of maternal health services by highlighting the need to re-think the way in which the social component of health care is integrated with the provision of medical services. The principle that in order to work well for women, health systems need to incorporate initiatives which address the social barriers to accessing care is well established. Yet in order to improve the prospects of women's reproductive health, we need to go beyond the principle of integrated community health services, and ask what an integrated health system that works well for women's health looks like. Such a system must not only fully integrate the delivery of social and advocacy services in addition to clinical care, but must do so in a way that constitutes a fundamental redistribution of power to women such that they have control over their lives and bodies.

Whilst there has been much progress in promoting integrated health programmes at a national and international level, the way in which this integration has been formulated often serves to undermine the social component, preventing women from receiving the full benefit of integrated health systems. Those who have advocated health systems which address the rights, concerns and experiences of women have seen these components reformulated into a set of instrumental measures which neglect the complex social relationships which underpin women's experience of reproductive health and health care. Women's health and rights advocates have argued that the root of the discord between social and clinical components can be found in the fundamentally biased way that health and development policy is thought of as a whole (Araujo and Diniz, 1990; Casterline and Sinding, 2000; Freedman, 2005). Whilst the architects of health policy continue to frame issues in maternal health care as technical concerns, they will continue to produce models of integrated health systems which make technical adjustments, but which fail to address the underlying social and political causes of maternal death.

Examining the experiences of health workers in Mali and Ghana does much to illuminate the tensions between social and clinical components. Where Malian health workers took it upon themselves to visit community members and advise them, the CHPS programme in Ghana sought to replicate these kinds of health care relationships by mandating health workers to do regular home visits, attend community events and generally integrate themselves into their communities. For the health workers in Shai-Osudoku, the social component of health service delivery has become a bureaucratic requirement, designed to address the problem of social barriers to health care. Here the social component has become part of the standard health services on offer, where social and cultural barriers are the problem, and health worker advocacy is the solution.

Health workers are required to conduct a considerable number of home and community visits, and this becomes the objective basis from which to judge how well they are implementing the social component of the programme. The social component has lost its potential to transform the health experiences of women and empower health workers to effect real change in their communities, and has become a simplified, measurable version which reflects the bureaucratic ideals of efficient service delivery. This blueprint for effecting the social side of health care does not

reflect the dynamic reality of the way in which productive health care relationships develop, nor does it acknowledge the power relations and widespread inequalities inherent in women's experiences of health care.

My analysis indicates that health care relationships and the strategies of the health workers who generate them are central to unlocking the potential of integrated health systems. Ethnographic evidence from both Mali and Ghana has shown that productive health care relationships are forged through the nuanced understandings and interactions of community members and health workers, and are constantly informed by the social and political contexts in which they take place. My discussion of health policy developments in chapter two pointed to the emergence of a health system ideology which, whilst it acknowledges that integrating social components is necessary for advancing women's health care, obscures the dynamic nature of the relationships which underpin women's experience of health and health care. I have argued that in order to better understand the causes of poor reproductive and maternal health, it is necessary to consider the experiences and approaches of health workers as well as the women whose reproductive health is at stake, and to acknowledge that the actions and understandings of actors involved must be understood as part of a broader system of power relationships with which they interact on a daily basis.

This analysis is supported by my theoretical approach outlined in chapter three, which highlights the dynamic nature of the actor strategies and relationships which underpin the everyday running of community health services. The ethnographic data explored here demonstrates that health workers routinely negotiate the project of integrating the social component, employing their own strategies where they are able in order to respond to deficits in the health systems in which they work. Their strategies play a central role in determining maternal outcomes every step of the way, from generating community networks to devising effective ways to advocate contraception and birth-spacing and aiding women and families in planning deliveries.

The project of integrating the social component with the provision of clinical services is therefore extraordinarily nuanced in practice, with health workers effecting this integration through daily negotiations with women, communities and elements of the health services in which they operate. Where health systems and infrastructure are not

conducive to successful implementation of the social component, health workers' strategies can undermine attempts to integrate this component, reflecting the gaps inherent in their respective health systems. In addition to navigating the project of integrating the social component, health workers also face the challenge of eking out a life for themselves as they live and work in their communities. Their efforts to build a place for themselves in their communities, to connect with women and their families and to cope with the demands of their respective health services have a significant impact on the efficacy of the social component of health service provision.

Ethnographic evidence from both Mali and Ghana suggests that the lives of health workers and the way they view their roles in their communities was crucial to their efficacy as health care providers. In Mali, health workers' understandings of their own roles and identity was a key part of explaining their compulsion to further advocacy and support work in their communities. They often viewed their respective roles as health service representatives and community members in a fluid way, moving between the formal and informal elements of their roles as demanded by a particular situation. Health workers in the less densely populated areas viewed their social and advocacy work – including having patients visit them at home or paying for those who could not afford medication – as central to their roles as community health workers, although this was not part of their formal mandate. Many felt their roles as health workers and community members were inseparable, and cited elements of trust and noblesse oblige that went with the role as the basis for their motivation.

Although the CHPS system in Ghana provided a formal model for health workers to integrate the social component of health care, many found that they were unable to use this as a platform for developing the necessary relationships in their communities. Some found that the requirement to make regular home visits prevented them from becoming trusted figures, with community members feeling intruded upon, or in some cases exposed by their visits. In the case of one community in which I worked, the CHO had been avoided and shunned by the community to which she was posted, and had a very negative view of the people there. She had reached a point where she felt her efforts were useless, and often did not complete the home visits required by the health service. In other cases, health workers found it difficult to cope with the realities of living and working in their respective clinics, feeling that they were always on duty and becoming resentful of being regularly approached by community

members. All health workers were troubled by safety issues, and felt unable to complete the number of community visits required due to the fact that they did not want to travel alone.

Whilst they are crucial to the successful integration of the social component, the impact of the individual experiences, understandings and strategies of health workers were not well reflected in the respective health service models, which constructed health workers as benign elements of the health system who can be empowered through training alone. The reality is that their informal strategies compensated for the inadequacies of health systems, to both positive and negative effect, and successful integration of social and clinical components of health care must take the dynamic nature of their health care relationships into account. The question of how this might be achieved goes to the broader issue highlighted by women's health advocates, who note the tendency of health policy to convert measures which could benefit women's health and rights into ineffective, anodyne solutions.

Integrating health and rights

Shore and Wright observe that 'policies are most obviously political phenomena, yet it is a feature of policies that their political nature is disguised by the objective, neutral, legal-rational idioms in which they are portrayed' (1997:8). The character of the dynamic relationships I have described here cannot be captured by a policy blueprint; they are a fundamental part of the everyday activities of health workers, and reflect the influence of embedded power relations and political interests which are forged at local, national and international levels. Although integrated health policies appear to be an efficient and effective means via which to incorporate social considerations which greatly impact women's health, the inherent power relationships and the political environments in which policies are formulated are disguised. As such, it is the work of all those who seek to improve women's health and rights to address the issue of how we might implement measures which achieve this, when the nature of policy is to repel the very elements which need to be at the heart of effective change.

It is often assumed in the arena of gender and development that policy is the site at which social change must be performed, yet despite considerable efforts to bring discourses of rights and power to bear on health policy, it continues to yield technical

solutions which fail to address the structural causes of inequality. Standing (2007) has argued that the issue here is not that health sector bureaucracies are failing to achieve this, but the assumption that they should be engines of social and political change. This work must happen elsewhere, through sustained dialogue between advocates of women's health and rights and the political agencies who generate the structures of governance which informs health policy. Let us first address the role of health systems and ask what it is in their power to do to provide services which work better for women.

Examining the everyday strategies of health workers as they respond to the inadequacies of health systems has been very instructive in this regard, as they reveal that the deficits in their respective health systems are often elements which in themselves are in the power of health systems to address through policy changes. The informal efforts of health workers in Mali to create health care relationships in their communities could be supported by the health system in numerous ways. Bolstering the roles of village relais through improved training and compensation would greatly help to further health care networks across communities, whilst creating space in the health care mandate for health workers to perform their advocacy work would enable them to reach more people. Improved feedback systems between CSCOM staff and community health associations would help coordinate these efforts, and allow health worker insights to benefit the design of community health services. In Ghana, health worker-focused policies including increased staffing could enable health workers to make community visits in pairs, protecting them whilst encouraging them to complete the necessary visits. Implementing an institutionalised feedback system and increasing the involvement of health workers in decision making could prevent situations in which communities are alienated by frequent, unnecessary visits. Improved communication and research on local areas could help health workers connect with areas they are not currently able to reach. Finally, the links between the community outreach element of the CHPS programme, enhancing women's rights and opportunities, and improved maternal outcomes should be much more clearly stated throughout policy and implementation.

Examining the problems experienced in integrating social and clinical components from this perspective suggests that there is much that advocates of women's health and rights can do to work with policy architects to improve the provision of maternal

health care. If we cannot expect health systems to start thinking in terms of the discourse of rights-based health policies, we can certainly highlight specific problems in the way in which health systems operate such as those I have mentioned above. In doing so, we open up the possibility of working with health policy architects to demonstrate which policy changes could lead to more equitable health systems, and a reduction in maternal mortality. Discussing the problems of attempting to implement broad feminist agendas into organisational settings, Razavi (1997) notes that different institutions have their own organising logic and culture, meaning that the strategies that might work in one context will not necessarily work in another. Therefore, in order to further the project of implementing rights-based approaches to maternal health, researchers must focus their attention on how discourses of women's health and rights can connect in practice to the exceedingly complex process of policy implementation in specific contexts rather than advocating panaceas for integrating 'gender' into various development institutions. In the case of improving maternal health systems, this means investigating the ways in which health systems can work better for women in specific local contexts.

The issue, then, is not that health systems repel the mechanisms necessary to affect social change, but that the avenues through which advocates might engage with those systems are lacking. This is not a problem to be addressed in technical terms at the level of institutions, but a fundamentally political one which requires that we address the structure of global governance and broad inequalities which underpin both the thinking behind health policies, and the experience of women in local contexts. As Freedman et al (2005) have stated, a chasm currently exists between the resources that we have available, what we know, and what we actually do. This is a reality which must be tackled on a global, political stage, rather than only at the level of health care institutions.

Conclusion

I have argued that maternal and reproductive health care is negotiated at a community level through the understandings and strategies of health workers who live and work in their communities. Health worker strategies have a significant impact on the provision and uptake of services, and the patterns produced by health worker strategies serve to highlight the deficits in the health systems in which they operate.

Discussions of how health systems might work better for women must therefore take into account the dynamic roles of health workers who play a pivotal part in determining maternal health care outcomes. Where health systems seek to integrate the provision of social and clinical services, understanding and supporting the role played by health workers in performing this integration is critical.

However, I have also shown that the strategies employed by health workers to plug gaps in their respective health systems only go so far where health workers have limited room to manoeuvre. Actor strategies not only shape the health systems of which they are a part, but are also shaped by these systems and by the broader political contexts to which these systems belong. I have shown that many of the problems experienced by health workers are technically within the remit of health systems to address, but in order to facilitate the necessary changes a far bolder set of systemic interventions are necessary. Whilst these systemic problems have not been the subject of my thesis, my micro-level investigations have highlighted the link between the experiences of health workers and the need for wide-reaching systemic action.

Whilst the purpose of this investigation was not to make specific policy recommendations with regards to the health systems that were the subject of the research, the evidence explored here has marked implications for the way in which community health policy may be understood and delivered. Examinations of the development of international healthcare policies and provisions combined with discussions of the historical development of the health systems of Mali and Ghana highlight the need to take into account the broader historical and political contexts when designing community health policy today. In both countries, the legacy of urban-centred development has been weak service infrastructure in rural areas, meaning that the architects of community health policy must consider not only the need to strengthen community health systems themselves, but also the impact of poor transport links, limited communication facilities, and weak district administration.

The evidence explored here from both contexts also highlights the need for community health policies to be explicit in addressing deep-seated gender inequalities and poverty. Many women's experience of health and health care in both countries is mediated through the social and economic difficulties they encounter on a daily basis,

a fact which should directly inform community health policy moving forward. The policy implications of the fact that there are multiple social, structural and economic factors which influence women's experience of health are considerable. Moving forward, community health systems will require mechanisms with which to address these multiple factors. The principal finding of this research has been that the role of community health workers in mediating the various factors which affect women's health and health care is critical. This suggests that expanding and developing the role of health workers may be a central means through which to broaden the scope of community health systems to address the multiple factors which undermine women's maternal health and rights.

Evidence from the community health systems of Mali and Ghana present several issues which have a significant bearing on policy approaches to the role of health workers. In both contexts, health workers exercised a considerable level of discretionary practice, using their own strategies and approaches both to improve women's experience of maternal and reproductive health care, and to mitigate the problems they encountered as health service workers. Their discretionary activities demonstrated their potential for advancing women's access to health services, and also helped to reveal areas of weakness in existing community health services. This suggests that health workers' roles in communities might usefully be enhanced in ways that maximise the utility of the knowledge and trust they gain when occupying their roles, and their potential to help develop community health system policy itself. Further, several health workers in both contexts expressed feelings of disenfranchisement, and were often isolated both geographically and politically from the health systems for which they worked. This suggests that the project of strengthening community health systems would benefit from an approach which enhances both the personal and professional circumstances of the health workers at the centre of service delivery.

In addition to enhancing the existing roles of community health workers, the findings explored here also suggest that maternal and reproductive health care would be advanced by expanding the roles of health workers in ways which would allow them to connect the health and advocacy work they do to broader development issues. Health workers in both contexts were often key figures in their communities, representing a bridge between community members and state and development

efforts. They also encountered numerous barriers to advancing women's health which stemmed not just from health system weaknesses, but from the broader problems posed by societal attitudes towards women, economic inequalities and weak transport and administrative infrastructures. This suggests that much would be gained by providing the means for health workers to connect their roles and activities to broader development issues and initiatives in their communities.

Increasing the numbers of staff, especially those with training in obstetric and emergency obstetric care, and developing health care infrastructure to ensure that women have full access to reproductive and obstetric care is essential. In order to ensure that women have access to these services, it is not only necessary to garner the political will on the part of development institutions, donors and governments to fully invest in strengthening health systems, but also to tackle the broader barriers to uptake of services. This means addressing the economic, social and political contexts in which health services are embedded. Finally, creating space for health workers to actively participate in programme feedback, monitoring and evaluation processes would do much to empower them to address the social elements which are so vital to fully integrated maternal health systems.

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